North Carolina Quality Assessment and Improvement Strategies
December 11, 2006 Status Report

I. Process for Quality Strategy Development, Review, and Revision

A. BBA-compliant WellPath (MCO) Contract:
The MCO model contract was finalized August 2003 to include the following BBA-compliant amendments. An extension of the current MCO contract for October 1, 2005 through June 30,, 2006 was approved by CMS.

In April 2006, the North Carolina Department of Health and Human Services (DHHS) made a decision to discontinue the MCO health care option for Medicaid recipients in Mecklenburg County. DHHS proposed an extension of the model contract through July 31, 2006 to ensure ample time to notify the MCO enrollees of the contract termination and transition to another health care option. CMS approved the State's request for the one-month extension of the contract.

The MCO contract states:

- The Plan must have an overall quality improvement program that is integrated into the Plan's activities and involves key decision-making staff.
- The Plan must submit annual reporting to include a patient and provider satisfaction survey annually, HEDIS data and DMA measures regarding utilization and Plan performance, quarterly complaint and grievances reports, and data for CSHCN.
- The Plan is required to develop and implement a minimum of two performance improvement projects that focus on clinical and non-clinical areas the first year, three projects in year two, and four projects in year three of the contract.
    1. The Plan submitted performance improvement project plans for four clinical projects: improving initial health assessment rates, improving lead screening rates, improving adolescent immunization rates, and improving health check screening rates. The results of these projects were reported by June 30, 2006 when the Plan reports their annual data to the State.

*** Please see Attachment I – the EQR 2006 Annual Technical Report**

    2. The Plan submitted a non-clinical performance improvement project for improving provider satisfaction. Results were reported by June 30, 2006 as required in the MCO contract.

B. BBA-compliant Piedmont Behavioral Healthcare (PIHP) Contract:
The PIHP contract was effective April 1, 2005 for a two-year period, with an optional one-year extension.

- The Plan must have an overall quality improvement program that is integrated into the Plan's activities and involves key decision-making staff.
- The Plan must submit annual reporting to include provider satisfaction survey, consumer satisfaction survey, HEDIS data and DMA measures regarding

utilization and Plan performance, quarterly complaint and grievances reports, and 1915 (c) waiver enrollee data.

On June 30, 2006, the PIHP reported the required annual performance measures for the first 9 months of operation, April 1, 2005 – December 31, 2005.

- The Plan is required to develop and implement a minimum of two performance improvement projects , one focusing on a clinical area and one non-clinical, during the first year of operation. Three projects are required in year two of the contract and four projects are required in year three. The results of these projects will be reported by July 31 of each calendar year beginning 7/31/06.

    1. The PIHP submitted the required non-clinical performance improvement project for year one of the contract for improving resolution of complaints within the established 30 day guideline.
    2. The PIHP clinical performance improvement project submitted was to improve continuity of care and reduce recidivism rates in state facilities through the involvement of the Screening Triage and Referral (STR) Department via discharge planning.

***Please see Attachment II - Piedmont Behavioral Healthcare Contract**

C. The third mandatory activity, Compliance with State and Federal Regulations, was completed for the PIHP on August 25, 2005. The document review and onsite activities were completed by the EQRO following the CMS protocol. MPRO accepted PBH's plan of correction and a letter was sent 3/30/06 to PBH indicating that they are in full compliance.

The next full regulatory Compliance review of the PIHP by the EQRO will be due in 2008.

D. The State plans to re-evaluate the quality strategy and revise it as necessary in the fourth quarter of each calendar year. The annual review and update of this quality strategy occurred in fourth quarter of 2006 through review of the information contained in this report and the attachments. The 2006 Quality Strategy will contain both PIHP updates, and HMO activities through the July 31, 2006 contract termination date. The Quality Strategy for 2007 will be specific only to the PIHP.

DMA participated in a PIHP stakeholder's meeting on October 13, 2006 at the PIHP's Meeting Conference location in Concord, North Carolina. The draft Piedmont specific Quality Strategy was presented for input and comment.

*****Please see **Attachment III - Stakeholders Global CQI Committee Meeting Agenda**

II. Managed Care Program Goals and Objectives

Upon termination of the MCO contract, the State discontinued the MCO Plan Mobilization Meetings quarterly in Mecklenburg County. The Division's Managed

Care Quality Management section continued to meet quarterly with the QM/UM representatives of the MCO Plan to discuss quality initiatives and progress toward goals until their final meeting held June 14, 2006 prior to termination of the HMO contract.

The Division's Managed Care Quality Management section also conducted quarterly meetings with the PIHP's QM staff regarding Performance Improvement Project (PIP) design and progress, EQR activities, performance monitoring reporting, identified trends, follow-up initiatives or action plans, and any other quality related topics of concern.

*** Please see Attachment IV - Samples of Agendas and Minutes for Quarterly QM Meetings held with the MCO and the PIHP**

III. Medicaid Contract Provisions

Contract provisions regarding access to care, accessibility of services, appointment availability and wait times, choice of a health professional, emergency services, structure and operations, or quality measurement and assessment have not been changed except for Sections 1.7, 2.2, 2.3, and Appendix IX, Grievance Procedures, Section C (except for the last two paragraphs). These sections of the MCO contract were amended in April 2004 to comply with BBA requirements.

***Please see the 2004 MCO contract amendment at http://www.dhhs.state.nc.us/dma/mco/amendmco.pdf**

IV. State Standards for Access to Care

State standards for access to care are covered in the MCO contract sections 6.2, 6.3, 6.4, 6.5, 6.6, 6.8, 6.14, 6.36, 7.6 and Appendix XV.

There has been no change with the MCO contract or state standards regarding access to care since the original strategy was submitted to CMS. However, DMA is in the process of proposing to amend the current MCO contract to reflect an update of the capitated rates and to clarify policy. The sections of the contract to be included in the amendment are: Section 6.14 Case Management for Children with Special Health Care Needs and Section 6.15 New Member Health Assessments.

State standards for access to care are covered in the PIHP contract sections 6.2, 6.3, 6.4, 6.5, 6.6, 6.8, 6.13, 6.22, 7.6, and Attachment U.

V. State Standards for Structure and Operations

There have been no changes to the MCO contract regarding structure and operations of the MCO since the original strategy was submitted to CMS. Structure and operations requirements are listed in sections 4.1-4.9, 6.11, 7.5, 7.6, 7.7, 8.2, 12.1, Appendix V and Appendix IX (amended).

Structure and operations requirements for the PIHP are listed in contract sections 4.1-4.8, 6.10, 6.11, 7.5, 7.6, 7.7, 8.3, 11.1, Attachment N, and Attachment P.

VI. State Standards for Quality Measurement and Improvement

1. Practice guideline requirements were assessed as part of the mandatory external quality review. Policy and procedures adopted by the Plan to develop appropriate practice parameters are compliant with Section 7.1 of the MCO contract and the PIHP contract.
2. The quality assessment and performance improvement program is included in Section 7.1 and Appendix XVII of the MCO contract and Attachment O of the PIHP contract.
3. The MCO contract states in Appendix V the statistical reporting requirements for the Plan, which are due by June 30 of each calendar year of the contract. The reporting includes HEDIS measures, CAHPS survey for children and adults, and measures developed by the Division to assess Plan performance. The annual reports are reviewed by Division Managed Care QM staff. Based on analysis of the results, the MCO may be required to submit a corrective action plan to the Division. The Plan had timely submission of all required reporting prior to termination of their contract.
4. The PIHP contract states in Attachment N the statistical reporting requirements for the PIHP with the annual measures due by July 31 of each calendar year of the contract. The PIHP had timely submission of required reporting.
5. Health Information systems requirements for the MCO are found in section 7.8 of the MCO contract. Utilization, provider and enrollee characteristics as specified by the Division are reported with the annual statistical report. Complaint, grievance and appeal data is submitted by the Plan to the Division on a quarterly basis. Involuntary disenrollments must be approved in advance by the Division after careful review of supporting information.
6. Health Information systems requirements for the PIHP are found in section 7.9 of the PIHP contract. Utilization, provider and enrollee characteristics as specified by the Division are reported with the annual statistical report. Complaint, grievance and appeal data is submitted by the Plan to the Division on a quarterly basis.

***Please see the MCO contract on the DMA website at:**
http://www.dhhs.state.nc.us/dma/mc/Finalmco.pdf

***Please see Attachment II - Piedmont Behavioral Healthcare Contract**

VII. State Monitoring and Evaluation

The State reviews the data submitted by the MCO and by the PIHP and provides feedback to each entity in Quarterly QM meetings and by written communication. The State works collaboratively with both Plans to determine topics for Performance Improvement Projects for the upcoming year based on a comparison of State and Plan-generated HEDIS measures. The State participated in EQRO site visit activities for the MCO July 20, 2006 and to the PIHP in an oversight capacity on August 31, 2006.

A. Arrangements for External Quality Reviews

1. Effective April 1, 2005, the State awarded the current EQRO contract for two years with a one year optional extension to Michigan Peer Review Organization (MPRO).
2. MPRO conducted an EQR site visit to the MCO on July 20, 2006 for Performance Improvement Project and Performance Measure Validation. Review of the ISCA tool was found to be in compliance for their information system capabilities. The MCO elected to accept the EQR reports for the 2006 Validation of Performance Improvement Projects and Performance Measures as the final report and chose not to submit a plan of correction for any recommendations due to termination of the contract effective July 1, 2006.
3. On April 20, 2006 MPRO conducted a site visit to the MCO to review the Financial Analysis; evaluate the contractual relationship between the State and MCO; evaluate the claims adjudication system and reporting methodology; and review compliance with the terms and conditions of the State/MCO contract. The MCO responded to the few items on the Plan of Correction and therefore demonstrated compliance.
4 MPRO conducted an EQR site visit to the PIHP on August 31, 2006 for Validation of Performance Measures and Performance Improvement Projects. The PIHP has been asked to submit a follow up corrective action plan for the recommendations to MPRO by October 31, 2006.
5. MPRO also reviewed the PIHP Information Systems Capabilities Assessment (ISCA) and found all documentation relating to the ISCA to be satisfactory, with the exception of the enrollment calculations for two performance measures, and the PIHP corrected the denominators of both of these measures to account for the accurate enrollment requirements.
6. MPRO submitted the Annual Technical Report to the State on October 31, 2006. The report was sent to both the MCO and PIHP for comment.
   ***** See **Attachment I – EQR 2006 Annual Technical Report**.
7. The ATR report will be used to evaluate the effectiveness of the State's quality strategy in the upcoming year.

VIII. Procedures for Race, Ethnicity, and Primary Language

A. The State is identifying the race, ethnicity and primary language of each Medicaid MCO/PIHP enrollee at the time of application at the DSS. The caseworker is entering the data into the Eligibility Information System (EIS) as instructed by the State. This information will be downloaded into the MMIS+ and DRIVE data systems and has been placed on the monthly MCO/PIHP enrollment reports.

B. Race is often not reported by the Social Security Administration for SSI recipients, therefore, we are coding the EIS as unreported when SSA sends us "unknown" as the race indication.

IX. National Performance Measures and Level

The State has incorporated performance benchmarks for the MCO in their contract. The benchmarks have been based on the NCQA HEDIS performance benchmarks for selected HEDIS measures, the MCO's self-reported data on specific State measures, and the benchmarks contained in the present contract. The State has accepted the MCO's HEDIS 2006 data report for CY 2005.

Since the PIHP now has an initial baseline year of service experience and performance data the State and the PIHP will jointly address the development of performance benchmarks.

X. Intermediate Sanctions

The State describes the use of intermediate sanctions in support of its quality strategy in section 14.5 of the MCO contract.

The PIHP contract section 13.2 addresses intermediate sanctions.

ATTACHMENT I

EQR 2006 ANNUAL TECHNICAL REPORT

ATTACHMENT II

PIEDMONT BEHAVORIAL HEALTHCARE CONTRACT

ATTACHMENT III

STAKEHOLDERS GLOBAL CQI COMMITEE MEETING AGENDA

ATTACHMENT IV

SAMPLES OF AGENDAS AND MINUTES FOR QUARTERLY QM MEETINGS HELD WITH THE MCO AND THE PIHP

www.dhhs.state.nc.us/dma/

nc dma

Division of Medical Assistance

2006 Annual Technical Report

October 31, 2006
Amended November 10, 2006
Final December 05, 2006

An independent external quality review of the State of North Carolina Division of Medical Assistance programs in accordance with the Balanced Budget Act of 1997.

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Executive Summary

The North Carolina Department of Health and Human Services (DHHS), Division of Medical Assistance (DMA) is responsible for evaluating the quality of care provided to recipients enrolled in North Carolina's Medicaid managed care organization (MCO) and Prepaid Inpatient Health Plan (PIHP). Pursuant to Federal requirements, as set forth in the Balanced Budget Act (BBA) of 1997 (BBA), DMA has contracted the Michigan Peer Review Organization (MPRO) to conduct a comprehensive review of each entity to assess performance relative to the quality of healthcare, timeliness of services, and accessibility of services to its enrollees.

DMA contracts with two entities. WellPath Select, Inc. (WellPath), a MCO operating in Mecklenburg County, provides services to Medicaid enrollees. Piedmont Behavioral Health (Piedmont), a PIHP, provides behavioral health services to Medicaid enrollees in multiple counties throughout the state.

This Annual Technical Report (ATR) provides an evaluation of review activities conducted by MPRO as the External Quality Review Organization (EQRO) to determine the progress both entities relative to meeting the goals set forth by the State. The report provides a detailed account of all review activities undertaken during the past year.

Review of WellPath Performance Improvement Projects

MPRO conducted a validation of four performance improvement projects (PIPs) submitted by WellPath. The following were the PIP study topics:

- Improving Adolescent Immunization Rates;
- Improving Initial Health Assessment Rates;
- Lead Screening Rates; and
- Improving Health Check Screening Rates.

The validation process produced findings of "Low Confidence" in two study topics: "Improving Initial Health Assessment Rates" and "Improving Health Check Screening Rates" and "Confidence" in two: "Improving Adolescent Immunization Rates" and "Improving Lead Screening Rates."

MPRO submitted recommendations related to the two "Low Confidence" PIPs. However, the contract between WellPath and DMA was terminated effective July 31, 2006; as a result, WellPath elected to accept the reports as final rather than submit a corrective action plan (CAP).

Review of WellPath Performance Measures

MPRO validated the same four performance measures (PMs) for WellPath in 2006 as validated in 2005:

- New Member Health Assessment for Pregnant Females;
- Children with Special Health Care Needs Assessment;
- Sterilizations Paid by Plan; and
- Hysterectomies Paid by Plan.

All four PMs were in full compliance.

WellPath has effectively utilized the DMA specifications for each measure. It was able to apply denominator exclusion criteria as applicable, identify numerators as appropriate, and meet all time limitations. MPRO did not note any weaknesses since all PMs met full compliance.

Review of Piedmont's Regulatory Compliance CAP

In 2005, MPRO conducted a regulatory compliance review of Piedmont. The review assessed Piedmont's compliance with federal, state, and DMA contractual requirements. The review findings indicated Piedmont had certain areas which did not meet full compliance. MPRO reviewed Piedmont's CAP and determined the CAP documents were complete, accurate, and in full compliance. The next full review will be completed in 2008.

Review of Piedmont Performance Improvement Projects

MPRO validated two PIPS for Piedmont:

- Improving Resolution of Complaints within Established Guidelines; and
- Improving Coordination of Care and Reducing Recidivism Rates in State Facilities.

MPRO's validation initially found "Confidence" in the first study – "Improving Resolution of Complaints within Established Guidelines." However, the "Improving Coordination of Care and Reducing Recidivism Rates in State Facilities" PIP resulted in a validation finding of "Low Confidence." MPRO recommended that Piedmont submit an updated PIP for the second study topic, including all recommendations from the final validation report, and to submit both PIPs in a final narrative report. On October 31, 2006 PBH submitted their CAP along with updated PIP reports. MPRO reviewed these reports and finds them to be in full compliance with the DMA/PIHP contract as required in the Balanced Budget Act (BBA) of 1997.

Review of Piedmont Performance Measures

MPRO validated seven of Piedmont's PMs:

- Follow-up After Hospitalization for Mental Illness;
- Mental Health Utilization;
- Chemical Dependency Utilization;
- Number of Consumers Moved from Institutional Care to Community Care;
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment;
- Utilization Management of the Provision of High Use Services; and
- Complaints/Grievances/Appeals.

MPRO found five of the seven PMs to be "Fully Compliant". On October 26, 2006 MPRO, Piedmont, and DMA had a conference call and Piedmont indicated that members cannot be disenrolled. Because of this, two of the performance measures were updated to 'Full Compliance'. For future performance measure reporting, MPRO has recommended that Piedmont develop a mechanism to differentiate between its Medicaid and State-funded enrollees in its databases.

Chapter 1 – Introduction

Purpose

The primary purpose of the Annual Technical Report (ATR), is to report the results of the independent evaluation performed in accordance with the Balanced Budget Act (BBA) of 1997 (Subpart E, 42 Code of Federal Regulations [CFR] §438.364). The ATR provides to the North Carolina Division of Medical Assistance (DMA) an assessment of each managed care organization (MCO) and Prepaid Inpatient Health Plan's (PIHP) compliance with the DMA Contract terms and conditions. The ATR also offers an objective report of each contracted entity's strengths and weaknesses relative to the quality, timeliness, and access of services provided to its enrollees. To achieve this purpose, Michigan Peer Review Organization (MPRO) conducted targeted review activities consistent with BBA requirements and Centers for Medicare & Medicaid Services (CMS) protocols.

CMS and DMA

CMS and DMA have a partnership, whereby CMS provides matching federal funds to DMA for administration and purchase of health care services for low-income enrollees. Medicaid has historically been based on a fee-for-service program; however, in 1981, the Omnibus Budget Reconciliation Act (OBRA) allowed state Medicaid agencies to enroll fee-for-service enrollees in federally qualified MCOs. The BBA is the first comprehensive revision of the federal requirements for Medicaid Managed Care programs.

The BBA enacted new Managed Care Regulations describing federal requirements for state Medicaid Managed Care Programs. Regulations 42 CFR §438.202 and §204 require the State's Medicaid Agency:

- Establish a state "Quality Strategy" describing the methods by which the DMA will comply with federal requirements and purchase managed health care services. The Quality Strategy must address DMA's proposed development and implementation of a quality assessment and improvement strategy that includes access to care, structure and operations, and quality measurement and improvement standards;[1]
- Contract with a qualified external quality review organization (EQRO) to assess State compliance with federal regulations;[2]
- Have the EQRO annually produce an objective public report focusing on each MCO and specifically addressing each MCO's strengths and weaknesses;[3] and
- Have Quality Strategy standards at least as stringent as the BBA standards [42 CFR §438.204(g)], with information obtained to be consistent with CMS protocols [42 CFR §438.350 (e)].

As stated in the federal regulations, DMA or its EQRO must perform three mandatory EQR-related activities covering each contracted MCO/PIHP:[4]

[1] 42 CFR §438.204-242.
[2] 42 CRF §438.204(d).
[3] 42 CFR §438.364 and §438.350.

1. Validate Performance Improvement Projects (PIPs);
2. Validate Performance Measures; and
3. Determine MCO/PIHP Compliance with Federal Medicaid Managed Care Regulations.

Through a competitive procurement process, DMA selected MPRO to conduct the required quality assessments and produce an annual detailed technical report.

Quality, Access, and Timeliness

The ATR is based on quality improvement principles espoused by W. Edwards Deming Ph.D. and Avedis Donabedian, MD, MPH. Deming's philosophy of Continuous Quality Improvement (CQI) requires a "constancy of purpose for the improvement of product and service" such that improvement efforts are focused on doing the right thing, at the right time, for the right reason.[5]

To operationalize ATR assessments, MPRO defined quality, access, and timeliness as follows:

- *Quality* is the extent to which an MCO/PIHP increases the likelihood of desired health outcomes of enrollees through its structural and operational characteristics, and through the provision of health care services consistent with current professional knowledge;
- *Access* is the extent to which appropriate and necessary services are available and obtainable to meet enrollee needs;[6] and
- *Timeliness* is the extent to which care and services are provided within the timeframes required in the DMA/MCO contract and federal regulations.[7] Timely interventions improve the quality of care and services provided, as well as enrollee and practitioner satisfaction, and are promoted through clinical quality and the continuity and coordination of care.

Reviewed Entities

The CFR describes state responsibilities to ensure a qualified EQRO performs an annual external quality review (EQR) for each contracting MCO or PIHP. DMA contracts with two entities, WellPath Select, Inc. (WellPath) and Piedmont Behavioral Health Care (Piedmont). WellPath, a MCO operating in Mecklenburg County, provides services to Medicaid enrollees. Piedmont, a PIHP, provides behavioral health services to Medicaid enrollees in multiple counties throughout the state. Information regarding the two entities follows.

WellPath Select, Inc.

WellPath is a regional health care management and benefits company based in North Carolina. WellPath's parent company, Coventry Health Care, is a national managed health care company based in Bethesda, Maryland, operating health plans, insurance companies,

[4] BBA requirement 42 CFR §438.358(b) (1-3).
[5] Walton M. *The Deming Management Method.* New York: Putnam Publishing Group; 1986.
[6] National Committee for Quality Assurance. *Standards and Guidelines for the Accreditation of MCO's.* Washington DC: 2006.
[7] Ibid.

network rental services companies, and worker's compensation services companies. WellPath provides and coordinates medical services for Medicaid enrollees on a full-risk capitated basis. The program, implemented pursuant to title XIX of the Social Security Act, the BBA, and Title 42 of the CFR, operates under the Medicaid State Plan in accordance with provisions contained in Section 1932 of the Social Security Act. WellPath subcontracts a portion of its work to Employee Health Systems (EHS), including medical management, customer services, claims processing and data analysis. MPRO worked directly with staff from both WellPath and EHS for the reviews. As the prime contractor, WellPath bears responsibility for its subcontractors' compliance with contractual and federal requirements; therefore, for the remainder of this ATR, both entities will be referred to as WellPath. Additional information regarding WellPath can be found on its website at http://www.wellpathonline.com.

Piedmont Behavioral Health Care

Piedmont began its business as a mental health clinic in the Cabarrus County Health Department in 1960. Piedmont is currently the third largest area program in the state and the largest multi-county area program, organized under North Carolina General Statue Chapter 122C, as a Local Management Entity. This program offers mental health, developmental disabilities, and substance abuse services. Piedmont serves Cabarrus, Davidson, Rowan, Stanly, and Union Counties for a total population of 644,000 people in over 2,459 square miles. Services are provided through a network of provider agencies and licensed practitioners located throughout the five counties and under contract with Piedmont. Additional information regarding Piedmont can be found on its website at http://www.Piedmontcare.org/about.asp.

EQR Methodology

MPRO conducted the activities for the reviews pursuant to a consistent methodology based on the CMS protocols. This methodology included the four steps described below.

STEP 1: Review DMA Requirements

MPRO met with DMA and reviewed background materials to confirm DMA's requirements for each MCO/PIHP. MPRO reviewed the Medicaid Managed Care Risk Contract between DMA and WellPath, as well as the Memorandum of Agreements between DMA and Piedmont. Specifications for each performance measure, as well as additional PIP policies concerning member eligibility, enrollment, report and data file formats, statistical reporting requirements, and performance benchmarks were used to develop a clear understanding of requirements to be fulfilled by each entity.

STEP 2: Document Review

Using the CMS protocols, MPRO identified documents to be reviewed for each activity and sent a request for the specific documents to the MCO or PIHP. Upon receipt of documents in hard copy and/or electronic formats, MPRO reviewed all documents checked for completeness. A second notice was then sent to the respective MCO or PHIP requesting missing or additional information. We then performed the desk audit (document review).

MPRO reviewed policies, procedures, and other documentation related to each Protocol and completed related worksheets prior to onsite interviews. The Protocol worksheets acted as a guide to determine the additional information requested to make judgments regarding the validity of PIPs, production and calculation of performance measures, and compliance with regulatory requirements.

STEP 3: Onsite Interviews

Conducting onsite interviews constituted the third step in the review process. The onsite interviews grant an opportunity for the MCO/PIHP representatives to provide additional information through questions and answers and presentation of supporting documentation. Prior to the interviews, the agenda for the meetings, worksheets, and a list of questions required to complete the analysis were sent to the MCO/PIHP to allow identification of appropriate personnel to participate in the onsite interviews.

The interviews occurred at WellPath (Morrisville, North Carolina) on July 20, 2006, and at Piedmont (Concord, North Carolina) on August 31, 2006. The WellPath and Piedmont interviews focused on discussions regarding both PIP and Performance Measure validation, as well as with the Information System Completeness Assessment (ISCA).

STEP 4: Report Results

MPRO recorded results of activities for the protocols using the various worksheets included in the CMS protocols. The worksheets were first completed based on the document review. These interim results were then used to determine discussion areas for the onsite interviews. Information collected during the onsite interviews, as well as supplementary documentation provided after the onsite interviews, were incorporated into the worksheets. MPRO provided DMA with draft copies of the worksheets, discussed the results, made appropriate adjustments, and shared the completed worksheets with WellPath and Piedmont.

PIP Validation Process

MPRO assesses PIPs consistent with ten steps described in the CMS Protocol:

1. Review the selected study topic(s);
2. Review the study question(s);
3. Review selected study indicator(s);
4. Review the identified study population;
5. Review sampling methods (if sampling was used);
6. Review the MCO's data collection procedures;
7. Assess the MCO's improvement strategies;
8. Review data analysis and interpretation of study results;
9. Assess the likelihood that reported improvement is "real" improvement; and
10. Assess whether the MCO has sustained its documented improvement.

The CMS guide for scoring overall assessment for the PIPs includes the final ratings of "High confidence in reported MCO PIP results," "Confidence in reported MCO PIP results, " "Low confidence in reported MCO PIP results." or "Reported MCO PIP results not credible."

PM Validation Process

MPRO's validation of PMs includes the following activities:

- Review of the MCO's data management processes;
- Evaluation of algorithmic compliance (the translation of captured data into actual statistics) with specifications defined by the State; and
- Verification of either the entire set or a sample of the State-specified performance measures to confirm the reported results are based on accurate source information.

There are four possible validation findings for each performance measure as defined below.

FC = **FULLY COMPLIANT**
Measure was fully compliant with DMA specifications.

SC = **SUBSTANTIALLY COMPLIANT**
Measure was substantially compliant with DMA specifications and had only minor deviations that did not significantly bias the reported rate.

NV = **NOT VALID**
Measure deviated from DMA specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required.

NA = **NOT APPLICABLE**
Measure was not reported because the MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

Strengths and Weaknesses

MPRO evaluated WellPath and Piedmont's PIPs and PMs to determine strengths and weaknesses related to the EQR activities. Strengths indicate the MCO/PIHP excels beyond the requirements, exceeding DMA and the enrollees' expectations of quality care and service.

Weaknesses result any time the MCO/PIHP does not comply with contract or regulatory requirements. Opportunities for improvement and ratings of low confidence or non-compliance, are generally the basis for any recommendations.

Chapter 2 – WellPath Findings

WellPath Performance Improvement Projects

MPRO's validation of PIPs is conducted in a manner consistent with the CMS protocol *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities* (Final Version, May 1, 2002). MPRO evaluated the results and integrity of PIPs implemented by WellPath. WellPath selected the following four study topics for PIPs in both 2005 and 2006:

1. Improving Adolescent Immunization Rates;
2. Improving Initial Health Assessment Rates;
3. Improving Lead Screening Rates; and
4. Improving Health Check Screening Rates.

2005 Corrective Action

The findings from the 2005 Validation of WellPath's PIPs demonstrated certain areas did not meet compliance with the standards and requirements specified by the CMS protocols. MPRO' submitted three recommendations for WellPath:

1. Fully document each PIP consistent with the CMS Protocol and submit results to DMA in a document separate from the MCO's annual report to DMA;
2. Implement the CMS 10-step methodology for conducting PIPs as referenced in the CMS Protocol; and
3. Submit a corrective action plan (CAP) to include:
    - the steps required to implement the CMS 10-step methodology for conducting the PIP;
    - the name of each person responsible for the action steps;
    - the date the action steps are to occur; and
    - the method of monitoring the CAP, such as updates given at the quarterly meetings (QM) with DMA, WellPath, and MPRO.

MPRO also recommended the CAP be included in the MCO's Quality Improvement (QI) Work Plan for the year. Both DMA and MPRO approved WellPath's submitted CAP.

2006 Validation of PIPs

The review was conducted using both document review and onsite interviews. The onsite interviews were conducted at WellPath in Morrisville, North Carolina, on July 20, 2006.

MPRO's findings after the initial desk review indicated a "Low Confidence" rating for all four PIPs. During the onsite visit, MPRO provided technical assistance to WellPath regarding the development and documentation of its PIPs. On July 24, 2006, WellPath submitted updated PIP reports. MPRO noted improvement in two PIPs, and the final findings are summarized in Table 1 below:[8]

Table 1. Summary of 2006 WellPath PIP Findings

Study Topic	Findings
Improving Adolescent Immunization Rates	**Confidence** in reported MCO PIP results.
Improving Initial Health Assessment Rates	**Low confidence** in reported MCO PIP results.
Improving Lead Screening Rates	**Confidence** in reported MCO PIP results.
Improving Health Check Screening Rates	**Low confidence** in reported MCO PIP results.

Strengths and Weaknesses

Strengths

Although WellPath continues to work on PIP topics designed to increase the likelihood that enrollees will have desired health outcomes, the documentation of the PIPs did not demonstrate these programs or documentation as such excel beyond the requirements. MPRO did not discover any strengths.

Weaknesses

WellPath had two PIP findings of low confidence levels. Although WellPath reported on the same four PIPs as in 2005 and were given recommendations and technical assistance in 2005 and 2006, the submitted reports did not meet full compliance with the CMS protocols.

Recommendations

MPRO recommends the following for WellPath by PIP study topic:

Improving Adolescent Immunizations Rates

- Establish a performance goal that *exceeds*, not meets current rate;
- Include information regarding the numerator and denominator, measurement period, the sources and codes used to pull the data;
- Provide information that indicators are related to identified health care guidelines and whether the study indicators have been piloted or field-tested;
- Explain HEDIS 2006 specifications;
- Include information to define the numerator for exclusions for "documented illness";
- Include the method of data collection from administrative and encounter data, i.e., codes used and measurement cycle;
- Include additional interventions targeted to increase physician compliance; and
- Provide documented statistical evidence that performance improvement is true improvement.

[8] The final PIP report can be found in Appendix A.

Improving Initial Health Assessment Rates

- Clarify the initial statement regarding the DMA Measure Initial Health Assessment (IHA) process;
- Include a narrative statement indicating the study population includes members with special health care needs;
- Clearly define the study indicators in the study description; and explain the indicators will measure changes in health status of the study population in both quantitative and qualitative terms;
- Provide information regarding the relationship between the study indicators and established health care guidelines;
- Provide information regarding how increasing the number of members who have an initial health risk assessment will improve clinical outcomes;
- Discuss limitations on data collection that may skew the results;
- Include a degree estimation regarding completeness of the automated data used for the PIP study indicators;
- Document a data analysis plan, including the results of the comparison of measurement year 2003, 2004, and 2005;
- Identify the individual responsible for the analysis of the data;
- Monitor outcomes at least quarterly and identify the total number of newly identified members reported to providers and calculate the number of members who did not have an initial health assessment performed;
- Include total outreach calls made in September 2005 to substantiate the claim that intervention resulted in an increase of percent of new members who received IHA within 90 days from 27% to 81% in one quarter;
- Provide a detailed analysis, including data to support the reported increase in IHAs within 90 days of enrollment;
- Provide factors that may affect the internal and external validity of the results;
- Expand the narrative to quantify the extent of the improvement and the follow-up activities; and
- Verify repeat measurements demonstrate the initial study findings.

Improving Lead Screening Rates

- Expand the description of WellPath's declining trend and demonstrate with relevant and specific relevant data how the 2003 rates for Lead Screening decreased by 5.8%;
- Provide information indicators are related to identified health care guidelines;
- Provide information regarding limitations on data collection that may skew the results;
- Explain methods for measurement of member satisfaction;
- Include the size of the measurement year 2005 study population in the narrative;
- Elaborate the methods by which the data analysis will be performed, barrier identification;
- Identify the individual responsible for the data analysis; and
- Identify the number of newsletters distributed to providers.

Improving Health Check Screening Rates

- Implement additional interventions in 2006 to improve outcomes;
- Monitor progress on a quarterly basis, rather than annually, to allow interventions to be implemented as indicated;
- Provide information on baseline data used to determine rationale/relevance to the membership;
- Include a statement indicating the study population includes members with special health

care needs;
- Provide information that indicators are related to identified health care guidelines and whether the study indicators have been piloted or field-tested;
- Provide information regarding limitations on data collection that may skew the results;
- Determine whether the indicator requires explicit or implicit criteria, i.e., parental refusal to have screening performed;
- Indicate the roles and responsibilities of staff member in the data collection process correlating with his/her experience; and
- Expand the narrative to include a detailed analysis of the data, in addition to the study results and barriers.

Since the contract between DMA and WellPath terminated effective July 31, 2006, DMA provided WellPath the option to submit a CAP. WellPath chose to accept these reports as final without further corrective action.

WellPath Performance Measures

MPRO conducts Validation of PMs is conducted using the CMS protocol *Validating Performance Measures: A Protocol for Use in Conducting Medicaid External Quality Review Activities*. MPRO validated the same four performance measures in 2005 and 2006.[9] The measure topics were:

1. New Member Health Assessment for Pregnant Females;
2. Children with Special Health Care Needs (CSHCN) Assessment;
3. Sterilizations Paid by Plan; and
4. Hysterectomies Paid by Plan.

2005 Corrective Action

The 2005 review disclosed that for both the "Hysterectomies Paid by Plan" and "Sterilizations Paid by Plan" measures reporting was based on received date versus paid date. MPRO advised WellPath to correct these data fields to paid dates. DMA and MPRO approved WellPath's CAP.

2006 Validation PMs

The PM review was performed in two steps. The first step was a desk review of documents submitted to MPRO by WellPath on July 1, 2006. For the second step, MPRO and State representatives met at WellPath for a face-to-face assessment of its compliance to the regulatory requirements. The onsite visit occurred on July 20th, 2006. During the onsite review, WellPath provided additional clarification and information related to the PMs, as well as its information systems capabilities.

The WellPath PM validation findings are outlined in Table 2:

[9] The final PM report can be found in Appendix B.

Table 2. Summary of 2005 WellPath PM Validation Findings

Measure	Findings
New Member Health Assessment (Pregnant Females)	**FC** - Measure was **fully compliant** with DMA specifications.
CSHCN Assessment	**FC** - Measure was **fully compliant** with DMA specifications.
Sterilizations Paid By Plan	**FC** - Measure was **fully compliant** with DMA specifications.
Hysterectomies Paid By Plan	**FC** - Measure was **fully compliant** with DMA specifications.

MPRO also determined all documentation relating to the Information Systems Capabilities Assessment were satisfactory.

Strengths and Weaknesses

Strengths

WellPath has effectively utilized the DMA specifications for each measure to produce performance measure report specification sheets. These sheets indicate the contract specifications, as well as the queries used to aggregate data and determine numerator and denominator hits. Demographics, including age, sex, and Medicaid enrollment were consistent throughout all queries for each PM.

WellPath was able to apply denominator exclusion criteria where applicable, such as for the CSHCN Assessment PM. WellPath documented the process for determining a child with special health care needs using the DMA/MCO CSHCN Assessment form indicated in the Case Management policy #UR-277.3. Special health care needs were categorized as clinical diagnoses; non-clinical diagnoses would not be included in the denominator.

Numerators were appropriately identified and met all time limitations such as within 15 business days after enrollment described in the New Member Health Assessment (Pregnant Females) measure.

All documentation relating to the ISCA was determined to be satisfactory.

Weaknesses

MPRO did not note any weaknesses, as all PMs met full compliance with DMA specifications.

Recommendations

Since all performance measures met full compliance with DMA specifications, MPRO made no recommendations for WellPath.

Chapter 3 – Piedmont Findings

Piedmont Regulatory Compliance

2005 Corrective Action

In 2005, MPRO conducted a regulatory compliance review of Piedmont using the CMS protocol *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for Determining Compliance with Medicaid Managed Care Proposed Regulations* at 42 CFR Parts 400, 430, et al. (Final Protocol Version 1.0, February 11, 2003). The review assessed Piedmont's compliance with federal requirements and DMA regulatory requirements, and was performed using document review and onsite interviews. The onsite interview was held at Piedmont in Concord, North Carolina on August 25, 2005. The final results of this review indicate Piedmont did not meet full compliance in certain areas. MPRO recommended the following:

- Develop priorities and a timetable for the preparation of remaining procedures that are necessary to meet compliance requirements, and have those procedures approved on an accelerated basis;
- Ensure procedures related to enrollee rights provide that enrollees are aware translation services are available free of charge;
- Expand written information to include distribution of guidelines to enrollees and providers;
- Document the methods and study design employed for developing access and availability studies;
- Include all timelines for UM decisions in applicable procedures;
- Ensure that Utilization Management (UM) Coordinators advise enrollees of eligibility for second opinions;
- Ensure the number of days for notifications on reductions, denials or terminations of service meet regulatory requirements; and
- Ensure the Notice of Action procedure meets the "no less than 20 days" filing requirements;

MPRO received and reviewed the requested CAP documents; the documents were determined to be complete and accurate. On March 30, 2006, MPRO sent Piedmont a letter indicating they were in full compliance. A follow-up compliance review will be completed in 2008.

Piedmont Performance Improvement Projects

Using the CMS protocol *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities,* MPRO validated the following two PIPS: [10]

1. Improving Resolution of Complaints within Established Guidelines; and
2. Improving Coordination of Care and Reducing Recidivism Rates in State Facilities.

The review was performed in four steps. The first step was a desk review of documents submitted to MPRO by Piedmont on August 1, 2006. For the second step, MPRO and State representatives met at Piedmont for a face-to-face assessment of its compliance with the regulatory requirements on August 31, 2006. Following the onsite, DMA agreed to allow Piedmont to re-submit the PIPs for additional desk evaluation (step three). The results of this review showed the following findings: Improving resolution of complaints within established guidelines- Confidence in reported MCO PIP results and Improving Coordination of Care and Reducing Recidivism Rates in State Facilities- Low Confidence in reported MCO PIP results. Then as suggested by MPRO, Piedmont submitted a corrective action plan with updated PIP reports on October 31, 2006. MPRO reviewed these PIPs and the findings contained within this report reflect the submitted changes.

The findings from the validation of the final amended PIPs are outlined in Table 3:

Table 3. Summary of 2005 Piedmont PIP Validation Findings

Study Topic	Findings
Improving Resolution of Complaints within Established Guidelines	**Confidence** in reported MCO PIP results.
Improving Coordination of Care and Reducing Recidivism Rates in State Facilities	**Low Confidence** in reported MCO PIP results. **11/06/06 Amended:** **Confidence** in reported MCO PIP results.

Strengths and Weaknesses

Strengths

Piedmont successfully updated the *Improving Resolution of Complaints within Established Guidelines* report and the *Improving Coordination of Care and Reducing Recidivism Rates in State Facilities* in accordance with MPRO's recommendations. The updates included evidence of topic selection, appropriate study questions, measurable indicators, clearly specifying the data to be collected, the source of the data, and interventions to be performed described in chronological order. Piedmont also, as part of the CAP, updated the reports using a narrative format.

Weaknesses

Although Piedmont did submit a CAP with updated PIP reports which were in full compliance, Piedmont did not initially follow the recommendations made by MPRO during the desk reviews and the onsite visit.

[10] The Final Amended PIP report can be found in Appendix C.

Recommendations

MPRO recommends Piedmont continue to use the CMS protocols for developing and updating their PIP reports. All final reports should be in a narrative format.

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Piedmont Performance Measures

MPRO validated Piedmont's PMs using the CMS protocol *Validating Performance Measures: A Protocol for Use in Conducting Medicaid External Quality Review Activities*. MPRO validated seven performance measures: [11]

1. Follow-up After Hospitalization for Mental Illness;
2. Mental Health Utilization;
3. Chemical Dependency Utilization;
4. Number of Consumers Moved from Institutional Care to Community Care;
5. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment;
6. Utilization Management of the Provision of High Use Services; and
7. Complaints/Grievances/Appeals.

The review was performed in three steps. The first step was a desk review of documents submitted to MPRO by Piedmont on July 31st, 2006. For the second step MPRO and State representatives met at Piedmont for a face-to-face assessment of its compliance to the regulatory requirements. The onsite visit occurred on August 31st, 2006. During the onsite review, Piedmont provided clarification and information relative to the PMs, as well as its information systems capabilities. For the third step, Piedmont supplied MPRO with additional information on September 18th as follow-up to questions from the onsite review.

Summary of Findings

On October 26, 2006 MPRO, Piedmont, and DMA had a conference call and Piedmont indicated that members cannot be disenrolled. Because of this, two of the performance measures were updated to "Full Compliance". The findings of the performance measure validation activity are now as follows:

The findings of the performance measure validation are outlined in Table 4:

[11] The Final Amended PM report can be found in Appendix D.

Table 4. Summary of 2006 Piedmont PM Validation Findings

Measure	Findings
Follow-up After Hospitalization for Mental Illness	**SC** - Measure was **substantially compliant** with DMA specifications and had only minor deviations that did not significantly bias the reported rate. **10/26/06 Amended:** **FC** - Measure was **fully compliant** with DMA specifications.
Mental Health Utilization	**FC** - Measure was **fully compliant** with DMA specifications.
Chemical Dependency Utilization	**FC** - Measure was **fully compliant** with DMA specifications.
Number of Consumers Moved from Institutional Care to Community Care	**FC** - Measure was **fully compliant** with DMA specifications.
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	**SC** - Measure was **substantially compliant** with DMA specifications and had only minor deviations that did not significantly bias the reported rate. **10/26/06 Amended:** **FC** - Measure was **fully compliant** with DMA specifications.
Utilization Management of the Provision of High Use Services	**FC** - Measure was **fully compliant** with DMA specifications.
Complaints/Grievances/Appeals	**FC** - Measure was **fully compliant** with DMA specifications.

Strengths and Weaknesses

Strengths

Piedmont has effectively utilized the DMA specifications for each measure to produce compliant performance measure reports. Each report accurately documents denominator population specifications and numerator specifications. All performance measures are calculated using administrative data. Sampling is not used for any PMs.

Weaknesses

All PMs were biased due to under-reporting, although the percentage of incomplete data is insignificant.

Recommendations

For future performance measure reporting, MPRO recommends that Piedmont develop a mechanism to differentiate between its Medicaid and State-funded enrollees in its databases. This will allow the ability to improve the functionality of its reporting capabilities and to track continuous enrollment as it relates to specific performance measures.

Appendices

Appendix A – WellPath Performance Improvement Project Validation Report

Introduction

MPRO conducted an independent external quality review of WellPath Select, Inc. in accordance with the Balanced Budget Act of 1997. The primary purpose of the audit was to validate WellPath's performance improvement projects (PIPs). The results of this audit are written in this report.

The review was performed in three steps. The first step was a desk top review of documents submitted to MPRO by WellPath on July 1, 2006. The second step occurred when MPRO along with State representatives met at WellPath for a face to face assessment of their compliance to the regulatory requirements. The onsite visit occurred on July 20th, 2006. Following the onsite, DMA agreed to allow WellPath to re-submit the PIPs along with greater narrative detail for additional desk evaluation. MPRO reviewed these PIPs and the findings contained within this report reflect the submitted changes.

MPRO validated four PIPS: Improving Adolescent Immunization Rates, Improving Initial Health Assessment Rates, Improving Lead Screening Rates, and Improving Health Check Screening Rates. The findings are as follows:

Study Topic	Findings
Improving Adolescent Immunization Rates	Confidence in reported MCO PIP results.
Improving Initial Health Assessment Rates	Low confidence in reported MCO PIP results.
Improving Lead Screening Rates	Confidence in reported MCO PIP results.
Improving Health Check Screening Rates	Low confidence in reported MCO PIP results.

NORTH CAROLINA 2006 EXTERNAL QUALITY REVIEW PERFORMANCE IMPROVEMENT PROJECT VALIDATION

Date(s) of evaluation: 7/5/06 and 7/27/06
On-site Review: 7/20/06
Final Report: 8/31/06

Demographic Information	
MCO Name:	**WellPath Select, Inc.**
Name of Performance Improvement Project:	**Improving Adolescent Immunization Rates**
Dates of Study Period:	**1/1/2005 – 1/31/2006**
Documents Reviewed:	**Conducting Performance Improvement Project Worksheet – Improving Adolescent Immunizations Rates**

Type of Delivery System (check all that are applicable)			
☐ Staff Model	☒ MCO	Number of Medicaid Enrollees in MCO or PIHP:	**8385**
☐ Network	☐ PIHP	Number of Medicare Enrollees in MCO or PIHP:	
☐ Direct IPA		Number of Medicaid Enrollees in Study:	**212**
☐ IPA Organization		Total Number of MCO or PIHP Enrollees in Study:	
Number of MCO/PIHP primary care physicians: **34**			
Number of MCO/PIHP specialty physicians: **174**			
Number of physicians in study: **34**			

I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY				
Step 1. REVIEW THE SELECTED STUDY TOPIC(S)				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
1.1- Was the topic selected through data collection and analysis of comprehensive aspect of enrollee needs, care and services?	☒	☐	☐	The clinical topic "Improving Adolescent Immunization Rate" was selected for WellPath's targeted improvement project. Need to state in more detail the rate of increase that was referenced in the NCQA State Of Health Care Quality 2005 report. Define the immunization rates for WellPath and compare to industry standard benchmarks. Need to

I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY				
Step 1. REVIEW THE SELECTED STUDY TOPIC(S)				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
				define the performance goals for 2004 and 2005 set by the Quality Management Committee. 072706 Rate of increase as stated in the NCQA State of Health Care Quality report and WellPath's rates are now included. Recommend establishing a performance goal that exceeds, not meets current rate.
1.2- Did the MCO's PIPs over time address a broad spectrum of key aspects of enrollee care and services?	☒	☐	☐	Unable to determine if over time the PIP will address key aspects of care and services. 072706 The required information is now included.
1.3- Did the MCO's PIPs over time include all enrolled populations; i.e., did not exclude certain enrollees such as those with special health care needs?	☐	☒	☐	The entire population of members age 13 was used for this study including children with special needs. 072706 This information was removed from the PIP but needs to be included in the current version.

Step 2: REVIEW THE STUDY QUESTION(S)				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
2.1- Was/were the study question(s) stated clearly in writing?	☐	☒	☐	The study question as stated asks, "Have all adolescent member received the recommended immunizations by their 13th birthday?" Recommend re-wording the study question to indicate what impact the interventions will have on the rate of immunizations for adolescents. Need to determine a study goal. 072706 Study question still needs to be clarified i.e., Does doing "actions" improve the percentage of adolescents who receive a Hepatitis B and a second dose of MMR by their 13th birthday? The study goal is identified which is to improve adolescent immunization rates so that they meet or exceed DMA benchmarks for Combination 1 and 11. Recommend establishing a goal that exceeds benchmark only.

Step 3: REVIEW SELECTED STUDY INDICATOR(S)				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
3.1- Did the study use objective, clearly defined, measurable indicators?	☐	☒	☐	The study description does not clearly define the study indicators or how they will measure changes in health status of the study population in quantitative and qualitative terms. Need to specify the use of a HEDIS performance measure as an indicator. 072706 Suggest including information on the numerator and denominator, measurement period, the sources and codes used to pull the data.
3.1(a) – Was/were the indicator(s) related to identified health care guidelines pertinent to the study question?	☐	☒	☐	Need to provide information that indicators are related to identified health care guidelines and if the study indicators have been piloted or field-tested.
3.1(b) – Was this an important aspect of care to monitor that made a difference to the MCO's / PIHP's beneficiaries?	☒	☐	☐	Need to provide information on how improving adolescent immunization status will impact outcomes of care. 072706 The required information is now provided.
3.1(c) – Were the data available either through administrative data, medical records or other readily accessible sources?	☐	☒	☐	Need to provide information on the data sources.
3.1(d) – Did limitations on the ability to collect the data skew the results?	☐	☒	☐	Need to provide information on limitations on data collection that may skew the results.
3.1(e) – Did these indicators require explicit or implicit criteria?	☐	☒	☐	Unable to determine if indicator requires explicit or implicit criteria, i.e., refusal by parents to have a child immunized or medical contraindications for receiving immunizations.
3.2- Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	☒	☐	☐	Need to expand the narrative to include what improved member outcomes the indicators measure. 072706 The required information is now provided

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
4.1- Did the MCO clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	☒	☐	☐	Need to quantify the at risk population. No information is given on continuous enrollment requirements 072706 The required information is now provided.
4.2- If the MCO studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?	☒	☐	☐	The entire population of members age 13 were used in the study. Need to explain HEDIS 2006 specifications. Need to include information for defining the numerator for exclusions for "documented illness".

Step 5: REVIEW SAMPLING METHODS				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
5.1- Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	☐	☐	☒	All members in the study age range were used. No sampling techniques were employed.
5.2- Did the MCO employ valid sampling techniques that protected against bias? *Specify the type of sampling or census used:*	☐	☐	☒	
5.3- Did the sample contain a sufficient number of enrollees?	☐	☐	☒	

Step 6: REVIEW DATA COLLECTION PROCEDURES				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
6.1- Did the study design clearly specify the data to be collected?	☒	☐	☐	The study needs to specify what data is to be collected. The study references 2006 HEDIS technical specifications but does not explain these requirements. 072706 Reference to the 2006 HEDIS technical specifications has been removed.
6.2- Did the study design clearly specify the sources of data?	☒	☐	☐	Need to expand the narrative that describes the data sources, i.e., where are the medical records located, i.e., Primary or Specialty

Step 6: REVIEW DATA COLLECTION PROCEDURES				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
				Provider office locations. Specify the date ranges for collecting the data. 072706 The narrative has been expanded to include the required additional information.
6.3- Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒	☐	☐	Need to explain the systematic method of data collection. 072706 The required additional information has been provided.
6.4- Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	☒	☐	☐	State overall results of the HDC audit. WellPath uses both an automated data collection process as well as a manual process. Explain the degree of completeness of the data from using these methods. 072706 The required additional information has been provided and identifies that the process is monitored through a certified HEDIS auditor.
6.5- Did the study design prospectively specify a data analysis plan?	☐	☒	☐	The study needs to describe a data analysis plan. 072706 HEDIS data collection process is described in the narrative. Need to include how the data is collected from administrative and encounter data, i.e., codes used and measurement cycle.
6.6- Were qualified staff and personnel used to collect the data?	☐	☒	☐	Need to indicate the experience and qualifications of the personnel used to collect the data. Explain the relationship between WellPath and Coventry staff for the medical record abstraction process. 072706 Recommend Including on page 6 who analyses the collected data.

Step 7: ASSESS IMPROVEMENT STRATEGIES				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
7.1- Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	☐	☒	☐	Need to clarify why a low number of outreach calls were placed 3/05-6/05. 072706 The required additional information is provided to quantify the number of outreach calls made. Still need to include additional interventions targeted to increase physician compliance.

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
8.1- Was an analysis of the findings performed according to the data analysis plan?	☒	☐	☐	Need to provide an explanation on how the analysis was performed. Need to quantify the improvement. 072706 The required additional information has been provided.
8.2- Did the MCO present numerical PIP results and findings accurately and clearly?	☒	☐	☐	Tables are missing the denominator data. 072706 The required additional information has been added.
8.3- Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	☒	☐	☐	Need to expand the narrative to describe how the analysis was performed. 072706 The required additional information has been provided.
8.4- Did the analysis of study data include an interpretation of the extent to which its PIP was successful and the follow-up activities?	☒	☐	☐	Need to provide information as to the extent of the improvement and the follow up activities. 072706 The required additional information has been provided.

Step 9: ASSESS WHETHER IMPROVEMENT IS REAL IMPROVEMENT				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
9.1- Was the same methodology as the baseline measurement used, when measurement was repeated?	☐	☒	☐	Unable to determine from narrative.

Step 9: ASSESS WHETHER IMPROVEMENT IS REAL IMPROVEMENT				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
9.2- Was there any documented, quantitative improvement in processes or outcomes of care?	☒	☐	☐	Unable to determine if the documented improvement was due to improvement of processes or outcomes of care. 072706 Improvement in immunization rates now is noted as due to improved outcomes of care.
9.3- Does the reported improvement in performance have "face" validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	☐	☒	☐	Unable to determine if the interventions impacted performance.
9.4- Is there any statistical evidence that any observed performance improvement is true improvement?	☒	☐	☐	Need to indicate why the Z-test was used. According to the study, the Z-test statistical analysis confirms significant improvement based on the results. 072706 Reference to Z-test has been removed. Need to provide documented statistical evidence that performance improvement is true improvement.

Step 10: ASSESS SUSTAINED IMPROVEMENT				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
10.1- Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐	☒	☐	Need to add outcomes of repeated measurements as performed. 072706 Unable to determine at this time if sustained improvement will be demonstrated over comparable time periods.

ACTIVITY 2. VERIFYING STUDY FINDINGS (OPTIONAL)				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
1. Were the initial study findings verified upon repeat measurements?	☒	☐	☐	Insufficient information given to verify that the initial study findings were found on repeat measurements. 072706 The study is audited to verify results.

ACTIVITY 3. EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY				
As currently written, the PIP does not give enough information to evaluate the validity and reliability of the study. 072706 Although the PIP is written in greater detail there are still opportunities for improvement.				
	Y	**N**	**N/A**	**RECOMMENDATIONS**
Totals	17	13	3	▪ Establish a performance goal that exceeds, not meets current rate. ▪ Include information on the numerator and denominator, measurement period, the sources and codes used to pull the data. ▪ Provide information that indicators are related to identified health care guidelines and if the study indicators have been piloted or field-tested. ▪ Explain HEDIS 2006 specifications. ▪ Include information for defining the numerator for exclusions for "documented illness". ▪ Include how the data is collected from administrative and encounter data, i.e., codes used and measurement cycle. ▪ Include additional interventions targeted to increase physician compliance. ▪ Provide documented statistical evidence that performance improvement is true improvement.
Check one:	☐ High confidence in reported MCO PIP results ☒ **Confidence in reported MCO PIP results.** ☐ Low confidence in reported MCO PIP results ☐ Reported MCO PIP results not credible			

MPRO

NORTH CAROLINA 2006 EXTERNAL QUALITY REVIEW PERFORMANCE IMPROVEMENT PROJECT VALIDATION

Date(s) of evaluation: 7/5/06 and 7/27/06
On-site Review: 7/20/06
Final Report: 7/31/06

Demographic Information	
MCO Name:	**WellPath Select, Inc.**
Name of Performance Improvement Project:	**Improving Initial Health Assessment Rates**
Dates of Study Period:	**1/1/2005 – 1/31/2006**
Documents Reviewed:	**Conducting Performance Improvement Initial Health Assessment Rates**

Type of Delivery System (check all that are applicable)			
☐ Staff Model	☒ MCO	Number of Medicaid Enrollees in MCO or PIHP:	**8135**
☐ Network	☐ PIHP	Number of Medicare Enrollees in MCO or PIHP:	
☐ Direct IPA		Number of Medicaid Enrollees in Study:	**1251**
☐ IPA Organization		Total Number of MCO or PIHP Enrollees in Study:	
Number of MCO/PIHP primary care physicians: **34**			
Number of MCO/PIHP specialty physicians: **174**			
Number of physicians in study: **34**			

I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1. REVIEW THE SELECTED STUDY TOPIC(S)

Component/Standard	Y	N	N/A	Comments
1.1 – Was the topic selected through data collection and analysis of comprehensive aspect of enrollee needs, care and services?	☒	☐	☐	The clinical topic "Improving Initial Health Assessment Rates" was selected for WellPath's targeted improvement project. A component of this process is accessing care. The narrative describes that the study is based on patterns of inappropriate utilization (ER use rates) and DMA contract requirements. Although these factors are important to operations, the study needs to focus on important aspects of members care such as improved

I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY				
Step 1. REVIEW THE SELECTED STUDY TOPIC(S)				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
				preventive measures as a result of having an initial Health Risk Assessment performed. Suggest doing a literature review to support the selection of the topic. Need to clarify why a decrease from MY 2003 reporting rate is used and not a more recent reporting date. Need to explain in more detail how the data was collected in the study selection process. 072706 The required additional information was provided on why the study topic was selected and how it relates to clinical outcomes. MY 2003 is now referenced as the baseline year.
1.2 – Did the MCO's PIPs over time address a broad spectrum of key aspects of enrollee care and services?	☒	☐	☐	The PIP spans a one-year time frame and includes all new enrollees who had no previous PCP relationships or chose a new PCP and received an initial health assessment within 90 days of enrollment. Recommend clarifying the initial statement about the DMA Measure Initial Health Assessment (IHA) process. For instance, by tabulating the number of completed assessments, WellPath will be able to determine compliance rates.
1.3 – Did the MCO's PIPs over time include all enrolled populations; i.e., did not exclude certain enrollees such as those with special health care needs?	☐	☒	☐	The entire population was used for the study including members with special health care needs. 072706 The above statement was removed in the second draft. The narrative needs to include a statement that the study population includes members with special health care needs.

Step 2: REVIEW THE STUDY QUESTION(S)				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
2.1 – Was/were the study question(s) stated clearly in writing?	☒	☐	☐	The study question: "Did new members to the plan have an initial health assessment visit with their PCP within 90 days of notification?" is clear, simple and answerable. Suggest rewording the question to

Step 2: REVIEW THE STUDY QUESTION(S)				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
				indicate whether the interventions will have an impact on the outcomes of care. 072706 Study question now includes the impact of the interventions on outcomes of care.

Step 3: REVIEW SELECTED STUDY INDICATOR(S)				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
3.1 – Did the study use objective, clearly defined, measurable indicators?	☐	☒	☐	The MCO must document the basis on which it has adopted an indicator citing research, guidelines analysis and other valid sources. The project lacks the necessary research and documentation to support the selection of the study indicator. The study description does not clearly define the study indicators or how they will measure changes in health status of the study population in quantitative and qualitative terms. Need to determine the goals of the study. 072706 The goal of the study now is identified to improve the MY 2004 rate by 5 percentage points. Other noted deficiencies remain.
3.1(a) – Was/were the indicator(s) related to identified health care guidelines pertinent to the study question?	☐	☒	☐	Need to provide information on how the indicators are related to established health care guidelines and if the study indicators have been piloted or field-tested.
3.1(b) – Was this an important aspect of care to monitor that made a difference to the MCO's / PIHP's beneficiaries?	☐	☒	☐	Need to provide information on how increasing the number of members who have an initial health risk assessment will improve clinical outcomes.
3.1(c) – Were the data available either through administrative data, medical records or other readily accessible sources?	☒	☐	☐	Need to provide information on the data sources. 072706 The data source has now been identified as claims.
3.1(d) – Did limitations on the ability to collect the data skew the results?	☐	☒	☐	Need to provide information on limitations on data collection that may skew the results.
3.1(e) – Did these indicators require explicit or implicit criteria?	☐	☒	☐	Unable to determine if indicators require explicit or implicit criteria.

Step 3: REVIEW SELECTED STUDY INDICATOR(S)				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
3.2 – Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	☒	☐	☐	The indicator is a process measure. Strong clinical evidence is needed linking the process being measured to the desired outcomes. Need to identify how WellPath will measure member satisfaction? 072706 The process to measure member satisfaction is identified in Section 6 but also needs to be included in Section 3.

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
4.1 – Did the MCO clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	☒	☐	☐	The narrative needs to define the members to whom the study question and indicators are relevant? Does the study include adults, children and infants ages 0-21? 072706 The narrative now states there are no age restrictions for the study population and includes all new enrollees who meet the enrollment criteria.
4.2 – If the MCO studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?	☐	☒	☐	Due to the capitation payment structure of PCPs and the quality of encounter documentation, the study reports incomplete encounter data that would include reporting on initial health assessments.

Step 5: REVIEW SAMPLING METHODS				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
5.1 – Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	☐	☐	☒	Sampling was not used
5.2 – Did the MCO employ valid sampling techniques that protected against bias? *Specify the type of sampling or census used.*	☐	☐	☒	This question is n/a.

Component/Standard	Y	N	N/A	Comments
5.3 – Did the sample contain a sufficient number of enrollees?	☐	☐	☒	This question is n/a.

Step 6: REVIEW DATA COLLECTION PROCEDURES				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
6.1 – Did the study design clearly specify the data to be collected?	☒	☐	☐	Study uses administrative data from the CPT codes specified in the report. Narrative needs to describe how WellPath determines that an IHA was performed at the visit. 072706 The required additional information has been provided.
6.2 – Did the study design clearly specify the sources of data?	☒	☐	☐	Main source of data is encounter data from the claims system via CMS1500, UB92, or EDI (ANSI 837)
6.3 – Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒	☐	☐	The study design and methodology does not include and estimation of the degree of completeness of the automated data used for the PIP study indicators.
6.4 – Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	☐	☐	☒	Data collection tools were not needed since the information was pulled from administrative claims data.
6.5 – Did the study design prospectively specify a data analysis plan?	☐	☒	☐	Need to document a data analysis plan. Need to include the results of the comparison of MY 2003, 2004 and include 2005.
6.6 – Were qualified staff and personnel used to collect the data?	☒	☐	☐	Job descriptions of the listed staff members are needed to sufficiently evaluate qualification levels. Need to add what Marilyn Diaz's role was in the study process. 072706 Suggest adding a column to the table on page 4 that indicates what roles and responsibilities each of the two individuals played in the data collection process that correlates with their experience. Identify who is responsible for the analysis of the data.

Step 7: ASSESS IMPROVEMENT STRATEGIES				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
7.1 – Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	☐	☒	☐	Study design does not demonstrate research or evidence of a causal link between intervention plan and desired outcomes. It is expected that interventions associated with improvement on quality indicators will be system interventions, i.e., educational efforts, changes in policies, targeting of additional resources, or other organization-wide initiatives to improve performance. Interventions that might have some short-term effect, but that are unlikely to induce permanent change are insufficient. Study does identify and address three barriers to the planned intervention: 1) under-reporting of encounters; 2) enrollee transportation; and 3) inadequate enrollee telephone and address information. However, the interventions need additional documentation and support to build the validity of the project. 072706 Recommend monitoring outcomes at least quarterly. Identify the total number of newly identified members reported to providers and calculate the number of members who did not have an initial health assessment performed. Recommend including how many outreach calls were made in September 2005 to substantiate that the intervention impacted an increase to 81%.

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
8.1 – Was an analysis of the findings performed according to the data analysis plan?	☐	☒	☐	No analysis plan was given. Need to include a detailed analysis including data to support the 5% increase.

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
8.2 – Did the MCO present numerical PIP results and findings accurately and clearly?	☒	☐	☐	Need to include tables for comparison of 2003, 2004 and 2005 rates. Need to have both the numerator and the denominator numbers in the table 072706 The required information is now provided.
8.3- Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	☐	☒	☐	Need to explain the results identified in the table, calculate the statistical significance and provide factors that may affect the internal and external validity of the results.
8.4- Did the analysis of study data include an interpretation of the extent to which its PIP was successful and the follow-up activities?	☐	☒	☐	Need to expand the narrative to quantify the extent of the improvement and the follow-up activities.

Step 9: ASSESS WHETHER IMPROVEMENT IS REAL IMPROVEMENT				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
9.1- Was the same methodology as the baseline measurement used, when measurement was repeated?	☐	☒	☐	Due to lack of data documentation and data sources, unable to determine if the same methodology as the baseline measurement was used.
9.2- Was there any documented, quantitative improvement in processes or outcomes of care?	☐	☒	☐	Insufficient information given to quantify the improvement in outcomes of care. 072706 The 4 percentage point increase is now noted. It did not meet the goal of improving MY 2005 results by 5 percentage points.
9.3- Does the reported improvement in performance have “face” validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	☐	☒	☐	Unable to determine if the interventions impacted performance.
9.4- Is there any statistical evidence that any observed performance improvement is true improvement?	☐	☒	☐	Need to indicate why the Z-test was used. According to the study, the Z-test statistical analysis confirms that there was a statistically significant

Component/Standard	Y	N	N/A	Comments
				improvement. Need to identify if improvement occurred in 2005. Narrative focuses on 2004 but study year is 2005. 072706 Statistical analysis information has been removed.

Step 10: ASSESS SUSTAINED IMPROVEMENT				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
10.1- Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐	☒	☐	Unable to determine if sustained improvement will occur over time.

ACTIVITY 2. VERIFYING STUDY FINDINGS (OPTIONAL)				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
1. Were the initial study findings verified upon repeat measurements?	☐	☒	☐	Insufficient information given to verify that the initial study findings were found on repeat measurements.

ACTIVITY 3. EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY
As currently written, the PIP does not give enough information to evaluate the validity and reliability of the study. 072706 Although the PIP is written in greater detail there are still opportunities for improvement.

	Y	N	N/A	RECOMMENDATIONS
Totals	11	18	4	▪ Recommend clarifying the initial statement about the DMA Measure Initial Health Assessment (IHA) process. ▪ Add a statement in the narrative that the study population includes members with special health care needs. ▪ Clearly define the study indicators in the study description. Explain how they will measure changes in health status of the study population in both quantitative and qualitative terms. ▪ Provide information on how the study indicators are related to established health care guidelines. ▪ Provide information on how increasing the number of members who have an initial health risk assessment will improve clinical outcomes. ▪ Discuss limitations on data collection that may skew the results. ▪ Include and estimation of the degree of completeness of the automated data used for the PIP study indicators. ▪ Document a data analysis plan including the results of the comparison of MY 2003, 2004 and 2005. ▪ Identify who is responsible for the analysis of the data.

	Y	N	N/A	RECOMMENDATIONS
				▪ Recommend monitoring outcomes at least quarterly. Identify the total number of newly identified members reported to providers and calculate the number of members who did not have an initial health assessment performed. ▪ Recommend including how many outreach calls were made in September 2005 to substantiate that the intervention impacted an increase to 81%. ▪ Include a detailed analysis including data to support the 5% increase. ▪ Provide factors that may affect the internal and external validity of the results. ▪ Expand the narrative to quantify the extent of the improvement and the follow-up activities. ▪ Verify that the initial study findings were found on repeat measurements.
Check one:	☐ High confidence in reported MCO PIP results ☐ Confidence in reported MCO PIP results ☒ **Low confidence in reported MCO PIP results** ☐ Reported MCO PIP results not credible			

NORTH CAROLINA 2006 EXTERNAL QUALITY REVIEW PERFORMANCE IMPROVEMENT PROJECT VALIDATION

Date(s) of evaluation: 7/5/06 and 7/27/06
On-site Review: 7/20/06
Final Report: 7/31/06

Demographic Information	
MCO Name:	**WellPath Select, Inc.**
Name of Performance Improvement Project:	**Improving Lead Screening Rates**
Dates of Study Period:	**1/1/2005 – 1/31/2006**
Documents Reviewed:	**Conducting Performance Improvement Project Worksheet-Improving Lead Screening Rates**

Type of Delivery System (check all that are applicable)			
☐ Staff Model	☒ MCO	Number of Medicaid Enrollees in MCO or PIHP:	**8385**
☐ Network	☐ PIHP	Number of Medicare Enrollees in MCO or PIHP:	
☐ Direct IPA		Number of Medicaid Enrollees in Study:	**420**
☐ IPA Organization		Total Number of MCO or PIHP Enrollees in Study:	

Number of MCO/PIHP primary care physicians: **34**

Number of MCO/PIHP specialty physicians: **174**

Number of physicians in study: **34**

I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1. REVIEW THE SELECTED STUDY TOPIC(S)

Component/Standard	Y	N	N/A	Comments
1.1- Was the topic selected through data collection and analysis of comprehensive aspect of enrollee needs, care and services?	☒	☐	☐	The clinical topic " Improving Lead Screening" was selected for WellPath's targeted improvement project. The worksheet references that 7% of the MCO's populations is comprised of children age 12 and 24 months, yet the article that establishes the need for lead screening references children one to five years of age. Need to provide information for WellPath's MY 2003/2004 reporting rates to quantify the amount of decrease in lead screening between these years.

I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY				
Step 1. REVIEW THE SELECTED STUDY TOPIC(S)				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
				Recommend additional sources of information and/or literature reviews to support the study relevance. 072706 The required additional information has been provided.
1.2- Did the MCO's PIPs over time address a broad spectrum of key aspects of enrollee care and services?	☒	☐	☐	Clinical focus of the study over time emphasizes preventive care. Need to expand the description of WellPath's declining trend and demonstrate how the 2003 rates decreased by 5.8% based on what specific relevant data?
1.3- Did the MCO's PIPs over time include all enrolled populations; i.e., did not exclude certain enrollees such as those with special health care needs?	☐	☒	☐	The entire membership ages 12 and 24 months were used in the study population including children with special health needs. 072706 The statement above was omitted in the second draft. Need to leave the statement in Section 1. The statement is also included in Section 4.

Step 2: REVIEW THE STUDY QUESTION(S)				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
2.1- Was/were the study question(s) stated clearly in writing?	☒	☐	☐	The study question as stated asks "Were all children who turned 12 and 24 months screened for lead"? Recommend rewording the study question to indicate whether the interventions will have an impact on the number of lead screenings performed. Need to determine a study goal. 072706 The study question is now clearly defined. The goal is to increase the MY 2003 rate by 5%.

Step 3: REVIEW SELECTED STUDY INDICATOR(S)				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
3.1- Did the study use objective, clearly defined, measurable indicators?	☒	☐	☐	The study description does not clearly define the study indicators or how they will measure changes in health status of the study population in quantitative and qualitative terms. 072706 The required additional information was provided to clearly define the study indicator.
3.1(a) – Was/were the indicator(s) related to identified health care guidelines pertinent to the study question?	☐	☒	☐	Need to provide information that indicators are related to identified health care guidelines and that the study indicators have been piloted or field-tested.
3.1(b) – Was this an important aspect of care to monitor that made a difference to the MCO's / PIHP's beneficiaries?	☒	☐	☐	Need to provide information on how improving lead screening will impact the study population. 072706 The required additional information was provided on the long-term adverse effects of childhood lead poisoning.
3.1(c) – Were the data available either through administrative data, medical records or other readily accessible sources?	☒	☐	☐	Need to provide information on the data sources. 072706 Narrative now identifies the data sources as enrollment and administrative data that includes claims and encounter data.
3.1(d) – Did limitations on the ability to collect the data skew the results?	☐	☒	☐	Need to provide information on limitations on data collection that may skew the results.
3.1(e) – Did these indicators require explicit or implicit criteria?	☐	☒	☐	Unable to determine if indicators require explicit or implicit criteria.
3.2- Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	☐	☒	☐	Need to expand the narrative to include what improved outcomes will the indicators measure. How will WellPath measure member satisfaction?

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
4.1- Did the MCO clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	☒	☐	☐	Include the size of the MY 2005 study population in the narrative

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
4.2- If the MCO studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?	☒	☐	☐	

Step 5: REVIEW SAMPLING METHODS				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
5.1- Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	☐	☐	☒	All members in the study age range were used. No sampling techniques were employed.
5.2- Did the MCO employ valid sampling techniques that protected against bias? *Specify the type of sampling or census used:*	☐	☐	☒	
5.3- Did the sample contain a sufficient number of enrollees?	☐	☐	☒	

Step 6: REVIEW DATA COLLECTION PROCEDURES				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
6.1- Did the study design clearly specify the data to be collected?	☒	☐	☐	Additional information is needed to clearly define the data elements, i.e., explain the type of encounter data used and explain the type of laboratory reports used to identify what laboratory screening had been performed. 072706 The required additional information was provided.
6.2- Did the study design clearly specify the sources of data?	☒	☐	☐	Specify the date ranges for collecting the data. 072706 Date ranges are now specified.
6.3- Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒	☐	☐	

Component/Standard	Y	N	N/A	Comments
6.4- Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	☒	☐	☐	Data collection is performed through a medical record review and from information documented on the NCIH website. Need to provide information on the data collection process and steps taken to ensure the process is consistent and collects accurate data over time. Need to provide information on interrater reliability audits. Study narrative indicates no data collection tools were used. Need to add how the data was tabulated from these sources? 072706 The narrative no longer references a medical record review process.
6.5- Did the study design prospectively specify a data analysis plan?	☒	☐	☐	Need to identify a data analysis plan. 072706 A data analysis plan is included in the narrative but still needs to include how the data analysis will be performed including identifying the barriers.
6.6- Were qualified staff and personnel used to collect the data?	☒	☐	☐	Need to include who was responsible for the data analysis.

Step 7: ASSESS IMPROVEMENT STRATEGIES

Component/Standard	Y	N	N/A	Comments
7.1- Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	☐	☒	☐	Dates for interventions need to be placed in order using a consistent format, either by quarter or by date. Fourth quarter 2004 interventions are included in the narrative yet the study period starts at 0101/05. Need to identify what was done to increase the response rate of the surveys above 12%. Education and outreach efforts are methods used to increase lead screening. WellPath should explore performing additional potentially effective strategies to increase lead screening such as offering incentives to provider or members, monitoring physician compliance, and engaging in early member outreach and education. Examples include sending materials to members as

Component/Standard	Y	N	N/A	Comments
				soon as they become pregnant and continue through birth and the child's' first and second birthdays. 072706 Interventions are listed in order by date however the number of newsletters distributed to providers needs to be identified.

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
8.1- Was an analysis of the findings performed according to the data analysis plan?	☐	☒	☐	Need to provide an explanation of the analysis that was performed.
8.2- Did the MCO present numerical PIP results and findings accurately and clearly?	☒	☐	☐	Need to add denominator data in the tables. 072706 The required additional information was added to the table on page 9.
8.3- Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	☐	☒	☐	Need to expand the narrative to describe how the analysis was performed.
8.4- Did the analysis of study data include an interpretation of the extent to which its PIP was successful and the follow-up activities?	☒	☐	☐	Need to expand the narrative to quantify the extent of the improvement and the follow-up activities. 072706 The required additional information was provided.

Step 9: ASSESS WHETHER IMPROVEMENT IS REAL IMPROVEMENT				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
9.1- Was the same methodology as the baseline measurement used, when measurement was repeated?	☐	☒	☐	Due to lack of data information and data sources, unable to determine if the same methodology as the baseline measurement was used.

Component/Standard	Y	N	N/A	Comments
9.2- Was there any documented, quantitative improvement in processes or outcomes of care?	☒	☐	☐	Need to expand the narrative to indicate if the quantitative improvement was a result of the process or outcomes of care 072706 The additional information required to identify the improvement was noted.
9.3- Does the reported improvement in performance have "face" validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	☒	☐	☐	Need to correlate the dates of the interventions with the improvement noted in lead screening. 072706 Improvement in lead screening rates now appears to be the result of the planned interventions.
9.4- Is there any statistical evidence that any observed performance improvement is true improvement?	☒	☐	☐	Need to indicate why the Z-test was used. According to the study, the Z-test statistical analysis confirms significant improvement of the results. 072706 Reference to Z-test was removed however no statistical evidence is documented.

Step 10: ASSESS SUSTAINED IMPROVEMENT				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
10.1- Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐	☒	☐	Data from only one year of study was provided. Unable to determine if sustained improvement will occur over time. 072706 Data is provided for 2003, 2004 and 2005. An improvement in lead screening is noted.

ACTIVITY 2. VERIFYING STUDY FINDINGS (OPTIONAL)				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
1. Were the initial study findings verified upon repeat measurements?	☒	☐	☐	Insufficient information given to verify that the initial study findings were found on repeat measurements. 072706 The required additional information was provided.

ACTIVITY 3. EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY				
As currently written, the PIP does not give enough information to evaluate the validity and reliability of the study. 072706 Although the PIP is written in greater detail there are still opportunities for improvement.				
	Y	**N**	**N/A**	**RECOMMENDATIONS**
Totals	20	10	3	▪ Expand the description of WellPath's declining trend and demonstrate how the 2003 rates decreased by 5.8% based on what specific relevant data? ▪ Provide information that indicators are related to identified health care guidelines ▪ Need to provide information on limitations on data collection that may skew the results. ▪ Explain how member satisfaction will be measured? ▪ Include the size of the MY 2005 study population in the narrative ▪ Elaborate on how the data analysis will be performed including identifying the barriers ▪ Need to include who was responsible for the data analysis ▪ Identify the number of newsletters distributed to providers.
Check one:	☐ High confidence in reported MCO PIP results ☒ **Confidence in reported MCO PIP results** ☐ Low confidence in reported MCO PIP results ☐ Reported MCO PIP results not credible			

NORTH CAROLINA 2006 EXTERNAL QUALITY REVIEW PERFORMANCE IMPROVEMENT PROJECT VALIDATION

Date(s) of evaluation: 7/5/06 and 7/27/06
On-site Review: 7/20/06
Final Report: 8/31/06

Demographic Information	
MCO Name:	**WellPath Select, Inc.**
Name of Performance Improvement Project:	**Improving Health Check Screening Rates**
Dates of Study Period:	**1/1/2005 – 1/31/2006**
Documents Reviewed:	**Conducting Performance Improvement Project Worksheet - Improving Health Check Screening Rates**

Type of Delivery System (check all that are applicable)			
☐ Staff Model	☒ MCO	Number of Medicaid Enrollees in MCO or PIHP:	**8385**
☐ Network	☐ PIHP	Number of Medicare Enrollees in MCO or PIHP:	
☐ Direct IPA		Number of Medicaid Enrollees in Study:	**1888**
☐ IPA Organization		Total Number of MCO or PIHP Enrollees in Study:	
Number of MCO/PIHP primary care physicians: **34**			
Number of MCO/PIHP specialty physicians: **174**			
Number of physicians in study: **34**			

I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1. REVIEW THE SELECTED STUDY TOPIC(S)

Component/Standard	Y	N	N/A	Comments
1.1- Was the topic selected through data collection and analysis of comprehensive aspect of enrollee needs, care and services?	☒	☐	☐	The clinical topic " Improving heath check screening rates" was selected for WellPath's targeted improvement project. Age identified for the demographic information does not compare to DMA requirements for screening members 21 years and under. Recommend stating WellPath's performance results for screening in the report. Suggest doing a literature review to support the importance of conducting this study.

I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY				
Step 1. REVIEW THE SELECTED STUDY TOPIC(S)				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
				072706 The PIP now describes sources that support the reason the study topic was chosen. It also identifies that health check screenings are a key component in proactive healthcare management and the impact on the membership based on demographic characteristics. The age requirement for screening has been corrected to include members under age 21 years of age that is now the same as the DMA requirements for screening. WellPath's performance rates for screening are included in Section 8. No information is given on WellPath's baseline data that was used to determine rationale/relevance to the membership.
1.2- Did the MCO's PIPs over time address a broad spectrum of key aspects of enrollee care and services?	☒	☐	☐	Recommend including DMA's Health Check Periodicity Schedule as an attachment. Same information is repeated in 3.2. Suggest expanding the narrative and removing repeated information from this section. 072706 A periodic screening table is included in Section 4. Repeated information has been removed.
1.3- Did the MCO's PIPs over time include all enrolled populations; i.e., did not exclude certain enrollees such as those with special health care needs?	☐	☒	☐	Clarify why only ages 0-20 are used in the sample. Study population does include members with special health needs. 072706 Age range of 0-21 is consistently being used. The PIP needs to include a statement that the study population includes members with special health care needs.

Step 2: REVIEW THE STUDY QUESTION(S)				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
2.1- Was/were the study question(s) stated clearly in writing?	☒	☐	☐	The study question as stated asks, " Have all children age 0-20 received a health check/ preventive health exam visits based on the Health Check Periodicity Schedule?" Suggest rewording the question to indicate whether the interventions had an impact on the outcomes of care. 072706 The study question is now a clear answerable question and includes the impact of the interventions on the outcomes of care.

Step 3: REVIEW SELECTED STUDY INDICATOR(S)				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
3.1- Did the study use objective, clearly defined, measurable indicators?	☒	☐	☐	Clarify if the age range is 0-20 or 0-21. Narrative needs to define how it will measure changes in the health status of the study population in quantitative and qualitative terms. 072706 Age range has been clarified
3.1(a) – Was/were the indicator(s) related to identified health care guidelines pertinent to the study question?	☐	☒	☐	Need to provide information that indicators are related to identified health care guidelines and if the study indicators have been piloted or field-tested.
3.1(b) – Was this an important aspect of care to monitor that made a difference to the MCO's / PIHP's beneficiaries?	☐	☒	☐	Need to provide information on why health check screening is an important aspect of care to monitor.
3.1(c) – Were the data available either through administrative data, medical records or other readily accessible sources?	☒	☐	☐	Need to provide information on the data sources. 072706 The data sources are identified as claims and encounter data.
3.1(d) – Did limitations on the ability to collect the data skew the results?	☐	☒	☐	Need to provide information on limitations on data collection that may skew the results.
3.1(e) – Did these indicators require explicit or implicit criteria?	☐	☒	☐	Need to determine if indicator requires explicit or implicit criteria, i.e., parent refusal to have screening performed.

Component/Standard	Y	N	N/A	Comments
3.2- Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	☐	☒	☐	Recommend expanding the narrative to describe what improved outcomes the indicators measure. 072706 Need to include information on measurement cycle i.e., annually or quarterly and how the indicator will improve member's health status. How will WellPath measure member satisfaction? 072706 The narrative now includes a description on how WellPath will measure member satisfaction. Need to identify sources of third party studies that indicate preventative healthcare is effective. 072706 Reference to third party studies has been removed.

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
4.1- Did the MCO clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	☒	☐	☐	Need to clarify the age range of study population. 072706 The age range has been clarified.
4.2- If the MCO studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?	☒	☐	☐	Need to provide information on how the data will be collected for both the denominator and the numerator i.e., enrollment files or claims. 072706 Information on how the data will be collected is included in Section 2.

Step 5: REVIEW SAMPLING METHODS

Component/Standard	Y	N	N/A	Comments
5.1- Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	☐	☐	☒	No sampling techniques were used.

Component/Standard	Y	N	N/A	Comments
5.2- Did the MCO employ valid sampling techniques that protected against bias? *Specify the type of sampling or census used:*	☐	☐	☒	
5.3- Did the sample contain a sufficient number of enrollees?	☐	☐	☒	

Step 6: REVIEW DATA COLLECTION PROCEDURES				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
6.1- Did the study design clearly specify the data to be collected?	☐	☒	☐	Describe the process for monitoring that all the components of the screening have been performed.
6.2- Did the study design clearly specify the sources of data?	☐	☒	☐	Specify the date ranges for collecting the data.
6.3- Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☐	☒	☐	How is the information obtained and tracked on the name of the physician and the office location? Identify who is collecting the data. 072706 Qualifications of the WellPath staff collecting the data is identified in the PIP.
6.4- Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	☐	☐	☒	
6.5- Did the study design prospectively specify a data analysis plan?	☐	☒	☐	No data plan was identified.
6.6- Were qualified staff and personnel used to collect the data?	☐	☒	☐	Identify Marilyn Diaz's role in the process. 072706 Suggest adding a column to the table on page 4 that indicates what roles and responsibilities each of the two individuals played in the data collection process that correlates with their experience.

Step 7: ASSESS IMPROVEMENT STRATEGIES				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
7.1- Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	☐	☒	☐	No barriers have been identified in the study. 072706 Barriers are now included. Need to include information used to calculate rate (42% increase). 072706 The required information has now been provided. Need to include interventions based on physician compliance. State the number of outreach calls performed and the number of mailings sent out. Interventions have not been performed consistently, i.e., missing interventions for the second quarter 2005. 07/2706 Second quarter interventions are included but not quantified i.e., how many PCP's exhibited consistently low encounter submissions and how many physicians had targeted education on the importance of encounter submissions. Recommend selecting different interventions then those on page 7 that would possibly lead to better outcomes.

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
8.1- Was an analysis of the findings performed according to the data analysis plan?	☐	☒	☐	Recommend expanding the narrative to include data used to calculate the 25% increase. 072706 The reference to the 25% increase has been removed. Recommend expanding the narrative to include a detailed analysis of the data in addition to the study results and barriers.

Component/Standard	Y	N	N/A	Comments
8.2- Did the MCO present numerical PIP results and findings accurately and clearly?	☒	☐	☐	State what study population is being screened in the table. 072706 Information in the table has been clarified Explain the abbreviation CSHCN.
8.3- Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	☒	☐	☐	
8.4- Did the analysis of study data include an interpretation of the extent to which its PIP was successful and the follow-up activities?	☒	☐	☐	Need to include what follow-up activities will be performed. 072706 Follow-up activities are now included.

Step 9: ASSESS WHETHER IMPROVEMENT IS REAL IMPROVEMENT				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
9.1- Was the same methodology as the baseline measurement used, when measurement was repeated?	☐	☒	☐	Due to lack of data information and data sources, unable to determine if the same methodology as the baseline measurement was used. 072706 Still unable to determine if the same methodology was used for the 2003 or 2004 measurement years.
9.2- Was there any documented, quantitative improvement in processes or outcomes of care?	☐	☒	☐	No improvement noted
9.3- Does the reported improvement in performance have “face” validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	☐	☒	☐	No improvement noted
9.4- Is there any statistical evidence that any observed performance improvement is true improvement?	☐	☒	☐	No improvement noted

Step 10: ASSESS SUSTAINED IMPROVEMENT				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
10.1- Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐	☒	☐	No improvement noted

ACTIVITY 2. VERIFYING STUDY FINDINGS (OPTIONAL)				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
1. Were the initial study findings verified upon repeat measurements?	☐	☒	☐	Insufficient information given to verify that the initial study findings were found on repeat measurements.

ACTIVITY 3. EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

As currently written, the PIP does not give enough information to evaluate the validity and reliability of the study.

07/27/06 Although the PIP is written in greater detail there are still opportunities for improvement.

	Y	**N**	**N/A**	**RECOMMENDATIONS**
Totals	10	19	4	▪ Recommend implementing additional interventions in 2006 to improve outcomes. ▪ Recommend monitoring progress on a quarterly basis instead of annually so that interventions can be implemented as indicated. ▪ Provide information on baseline data that was used to determine rationale/relevance to the membership. ▪ Include a statement that the study population includes members with special health care needs. ▪ Provide information that indicators are related to identified health care guidelines and if the study indicators have been piloted or field-tested ▪ Provide information on limitations on data collection that may skew the results. ▪ Determine if indicator requires explicit or implicit criteria, i.e., parent refusal to have screening performed. ▪ Suggest indicating what roles and responsibilities staff member played in the data collection process that correlates with their experience. ▪ Recommend expanding the narrative to include a detailed analysis of the data in addition to the study results and barriers.
Check one:	☐ High confidence in reported MCO PIP results ☐ Confidence in reported MCO PIP results ☒ **Low confidence in reported MCO PIP results** ☐ Reported MCO PIP results not credible			

Appendix B – WellPath Performance Measure Validation Report

Introduction

MPRO conducted an independent external quality review of WellPath Select, Inc. in accordance with the Balanced Budget Act of 1997. The primary purpose of the audit was to validate WellPath's Performance Measures (PMs). The results of this audit are written in this report. The validation activities address:

1. Review of the data management processes of the MCO;
2. Evaluation of algorithmic compliance (the translation of captured data into actual statistics) with specifications defined by the State; and
3. Verification of either the entire set or a sample of the State-specified performance measures to confirm that the reported results are based on accurate source information.

The review was performed in two steps. The first step was a desk top review of documents submitted to MPRO by WellPath on July 1, 2006. The second step occurred when MPRO along with State representatives met at WellPath for a face to face assessment of their compliance to the regulatory requirements. The onsite visit occurred on July 20th, 2006. During the onsite review, WellPath provided additional clarification and information related to the Performance Measures as well as their information systems capabilities. There are four possible validation findings for each performance measure as defined below.

POSSIBLE VALIDATION FINDINGS		
FC	=	**FULLY COMPLIANT** Measure was fully compliant with DMA specifications
SC	=	**SUBSTANTIALLY COMPLIANT** Measure was substantially compliant with DMA specifications and had only minor deviations that did not significantly bias the reported rate
NV	=	**NOT VALID** Measure deviated from DMA specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required
NA	=	**NOT APPLICABLE** Measure was not reported because WellPath did not have any Medicaid enrollees that qualified for the denominator

MPRO validated four performance measures: New Member Health Assessment for Pregnant Females; Children with Special Health Care Needs Assessment; Sterilizations Paid by Plan; and Hysterectomies Paid by Plan. The findings are as follows:

Measure	Findings
New Member Health Assessment (Pregnant Females)	**FC** - Measure was **fully compliant** with DMA specifications.
Children with Special Health Care Needs (CSHCN) Assessment	**FC** - Measure was **fully compliant** with DMA specifications.
Sterilizations Paid By Plan	**FC** - Measure was **fully compliant** with DMA specifications.
Hysterectomies Paid By Plan	**FC** - Measure was **fully compliant** with DMA specifications.

All documentations relating to the Information Systems Capabilities Assessment are satisfactory.

DEFINITIONS	
Met:	The MCO's measurement and reporting process was fully compliant with State specifications.
Not Met:	The MCO's measurement and reporting process was not compliant with State specifications. This data element should be used for any audit element that deviates from the State specifications, regardless of the impact of the deviation on the final rate. All audit elements with this designation must include an explanation of the deviation in the comments section.
N/A:	The audit element was not applicable to the MCO's measurement and reporting process.

MPRO

PERFORMANCE MEASURMENT VALIDATION WORKSHEET

PERFORMANCE MEASURE:	New Member Health Assessment (Pregnant Females)

METHODOLOGY FOR CALCULATING MEASURE: (check one)	☒ Administrative ☐ Hybrid ☐ Medical Record

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes	☒	☐	☐	Tab 7 in WellPath document binder contains all the appropriate data sources, program logic and source codes.
DENOMINATOR					
1. Population	Medicaid population appropriately segregated from commercial/Medicare Population defined as effective Medicaid enrollment as of December 31, 2005	☒	☐	☐	P1 in carrier field indicates the WellPath Medicaid population. Query step 2 used to determine the denominator for New Member Health Assessment for Pregnant Females. Extraction Process indicates the use of P1.
2. Geographic Area	Includes only Medicaid enrollees served in Mecklenburg County	☒	☐	☐	See Denominator 1.Population. Receives Mecklenburg County claims only
3. Age & Sex	No age specified Only females selected	☒	☐	☐	Query step 13 used to determine the denominator for New Member Health Assessment for Pregnant Females Extraction Process indicates sex = F

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
4. Enrollment Calculation	Were members of plan as of 12/31/05 Were continuously enrolled for at least three months from the date of enrollment	☒	☐	☐	Query step 3 used to determine the denominator for New Member Health Assessment for Pregnant Female. Extraction Process indicates at least three months of continuous enrollment. (under description, criteria for Medicaid members is to be enrolled for 4 months which differs from the query step 3)
5.Data Quality	Based on the IS process audit findings, are any of the data sources for this denominator inaccurate?	☒	☐	☐	WellPath uses Health Trio Xpress as its data sources for this measure.
6. Proper Exclusion Methodology in Administrative Data (if no Exclusions were taken, check NA)	Members with an established relationship with an OB provider Exclusions were performed according to current specifications Duplicate members identified with multiple date spans for eligibility are consolidated into one member record	☒	☐	☐	Exclusion criteria were applied appropriately. Although members with an established OB are indicated in the final assessment file, it is unclear how this information is determined in the query steps (under tab 7 this exclusion criteria is optional) Query step 4 used to determine the denominator for New Member Health Assessment for Pregnant Females. Extraction Process removes duplicates.

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
NUMERATOR					
7. Administrative Data: Counting Clinical Events	Standard codes listed in specifications or properly mapped internally developed codes were used Members are counted only once; double counting of New Member Assessment was prevented	☒	☐	☐	Standard codes were properly mapped according to specifications in the Numerator query 4 and 5.
8. Medical Review Documentation Standards	Record abstraction tool required notation of the date that the New Member Assessment was performed	☐	☐	☒	Medical Record Review was not used for this measure.
9. Time Period	New Member Assessment was performed on or between 1/1/05 & 12/31/05 New Member Assessment must be performed within 15 days of enrollment	☒	☐	☐	Several queries within the member extraction process determined that the New Member Assessment was performed within the measurement year (including query 2, 3 and 13).
10. Data Quality	Properly identify enrollees Based on the IS process audit findings, are any of the data sources used for this numerator inaccurate?	☒	☐	☐	Enrollees have been properly identified in the numerator using Health Trio *Xpress.*
SAMPLING	IF ADMINISTRATIVE METHOD WAS USED, CHECK N/A FOR AUDIT ELEMENTS 11, 12 AND 13				
11. Unbiased Sample	Systematic sampling method is utilized	☐	☐	☒	Sampling was not used for this measure.
12. Sample Size	After exclusions, sample size is equal to (1) the appropriate reduced sample size, which used the current year's administrative rate pr preceding year's report rate, (2) the total population	☐	☐	☒	Sampling was not used for this measure.

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
13. Proper Substitution Methodology in Medical Record Review (If no exclusions were taken, check NA)	Only exclude members for whom medical record review revealed (1) contraindications that correspond to the codes listed in appropriate specifications or (2) data errors. Substitutions are made for properly excluded records and the percentage of substituted records was documented	☐	☐	☒	Sampling was not used for this measure.

ADDITIONAL QUESTIONS

QUESTIONS	YES	NO
Were members excluded for contraindications found in the administrative data?	☒	☐
Were members excluded for contraindications found during the medical record review?	☐	☒
Were internally developed codes used?	☐	☒

What range defines the impact of data incompleteness for this measure? (Check one)	
0 - 5 percentage points	☐
>5 - 10 percentage points	☐
>10 - 20 percentage points	☐
>20 - 40 percentage points	☐
>40 percentage points	☐
Unable to determine	☒

What is the direction of the bias? Check one: **No bias found in the review**	☐Over-Reporting ☐Under-Reporting

COMMENTS

- All appropriate efforts are made to capture complete data.
- Denominator has all exclusion and inclusion criteria applied appropriately. Established queries utilizing Access XP database are sufficient to pull the appropriate members eligible for this measure (see note above).
- Numerator hits were appropriately determined to be within 15 business days after enrollment.

Upon what documentation is the above percentage based? (e.g., internal reports, studies, comparison to medical records, etc.)

COMMENTS:

- Tab 7 of the WellPath documentation entitled, "Documents for New Member Health Assessment"
- Documentation of Queries for New Member Health Assessment (Query-Denominator, Query-Numerator
- Performance Measures list provided by WellPath according to Performance Measure Validation Protocol
- DMA contract with WellPath Select, Inc. Appendix V, "Statistical Reporting Requirements"
- Onsite and phone interview with several WellPath personnel.

VALIDATION FINDING

FC = **FULLY COMPLIANT**
Measure was fully compliant with DMA specifications

SC = **SUBSTANTIALLY COMPLIANT**
Measure was substantially compliant with DMA specifications and had only minor deviations that did not significantly bias the reported rate

NV = **NOT VALID**
Measure deviated from DMA specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required

NA = **NOT APPLICABLE**
Measure was not reported because WellPath did not have any Medicaid enrollees that qualified for the denominator

AUDIT DESIGNATION	=	FC

MPRO

PERFORMANCE MEASURMENT VALIDATION WORKSHEET

PERFORMANCE MEASURE:	Children w/ Special Health Care Needs (CSHCN) Assessment

METHODOLOGY FOR CALCULATING MEASURE: (check one)	☒ Administrative ☐ Hybrid ☐ Medical Record

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes	☒	☐	☐	Tab 6 in WellPath document binder contains all the appropriate data sources, program logic and source codes. Case Management: Children With Special Health Care Needs Policy # UR-227.3 establishes a procedure for documentation of numerator hits.
DENOMINATOR					
1. Population	Medicaid population appropriately segregated from commercial/Medicare Population defined as effective Medicare enrollment as of Dec. 31, 2006	☒	☐	☐	Case Management: Children With Special Health Care Needs Policy # UR-227.3 documents the procedure to establish the appropriate denominator population, including initial identification of eligible members by DMA and subsequent follow-up by the Case Management Department.
2. Geographic Area	Includes only Medicaid enrollees served in Mecklenburg County	☒	☐	☐	See above.
3. Age & Sex	Members ages 0-20	☒	☐	☐	See above.

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
4. Enrollment Calculation	Eligible during the time of assessment (enrollment to 45 days)	☒	☐	☐	Case Management: Children With Special Health Care Needs Policy # UR-227.3 documents that the IS Department will provide an enrollment file to the UM Department which identifies CSHCN members.
5.Data Quality	Based on the IS process audit findings, are any of the data sources for this denominator inaccurate?	☒	☐	☐	See above.
6. Proper Exclusion Methodology in Administrative Data (if no Exclusions were taken, check NA)	Only members with contraindications or data errors may be excluded. Contraindication exclusions are allowed only as per current State specifications Only the codes listed in specifications are counted as contraindications	☒	☐	☐	Although there may be no viable procedure to retroactively confirm exclusions, according to the on-site interview, the MCO allows members to self-exclude themselves from the denominator if the parent/guardian states that the assessment is inappropriate.
NUMERATOR					
7. Administrative Data: Counting Clinical Events	Members are counted only once; double counting of CSHCN is prevented	☒	☐	☐	Assessment of the Excel spreadsheet shows members and assessment are only counted once.
8. Medical Review Documentation Standards	Record abstraction tool required notation of the date that the CSHCN was performed	☐	☐	☒	Medical Record Review was not used for this measure.

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
9. Time Period	The needs assessment needs to be performed within 30 calendar days of enrollment Or three documented attempts to do the assessment within 45 days of enrollment CSHCN Assessment performed on or between 1/1/05 & 12/31/05	☒	☐	☐	Needs assessments were not conducted during the DMA approved time frame of 30 days after the date of notification. (Reference: IPANC CSHCN Log 2005) Attempts were documented by date within an Excel file. Assessments were conducted during the 2005 measurement year.
10. Data Quality	Properly identify enrollees	☒	☐	☐	See above. (Reference: IPANC CSHCN Log 2004)
SAMPLING	IF ADMINISTRATIVE METHOD WAS USED, CHECK N/A FOR AUDIT ELEMENTS 11, 12 AND 13				
11. Unbiased Sample	• Systematic sampling method is utilized	☐	☐	☒	Sampling was not used for this measure.
12. Sample Size	• After exclusions, sample size is equal to (1) the appropriate reduced sample size, which used the current year's administrative rate pr preceding year's report rate, (2) the total population	☐	☐	☒	Sampling was not used for this measure.
13. Proper Substitution Methodology in Medical Record Review (If no exclusions were taken, check NA)	• Only exclude members for whom medical record review revealed (1) contraindications that correspond to the codes listed in appropriate specifications or (2) data errors. • Substitutions are made for properly excluded records and the percentage of substituted records was documented	☐	☐	☒	Sampling was not used for this measure.

ADDITIONAL QUESTIONS

QUESTIONS	YES	NO
Were members excluded for contraindications found in the administrative data?	☒	☐
Were members excluded for contraindications found during the medical record review?	☐	☒
Were internally developed codes used?	☐	☒
What range defines the impact of data incompleteness for this measure (Check one)		
0 - 5 percentage points		☐
>5 - 10 percentage points		☐
>10 - 20 percentage points		☐
>20 - 40 percentage points		☐
>40 percentage points		☐
Unable to determine		☒
What is the direction of the bias? Check one: **No bias found in the review.**	☐ Over-Reporting ☐ Under-Reporting	

COMMENTS

- The process for determining a child with special health care needs is documented using the North Carolina DMA/MCO CSHCN Assessment form indicated in the Case Management: Children With Special Health Care Needs Policy # UR-277.3. Special health care needs are categorized as clinical diagnoses according to the assessment form, children with non-clinical diagnoses would not be included in the denominator. This policy was approved by DMA, and will therefore be accepted.
- Representatives from WellPath stated in telephone and on-site interviews, that numerator hits are determined by an assessment done within 30 days of enrollment. The data shows that the MCO is appropriately following the timeframe specifications for the CSHCN measure. In addition, the supporting documents assess attempts within 45 days. The data CD entitled, "IPANC CSHCN Log 2005" sent by Marilyn Diaz, was used for the measures. The enrollment file is sent monthly to the plan which may result in fewer than 30 days to provide assessment and support.

Upon what documentation is the above percentage based? (e.g., internal reports, studies, comparison to medical records, etc.)

COMMENTS:

- Tab 6 of the WellPath documentation entitled, "Documentation for CHSCN and Health Check Screening
- Performance Measures list provided by WellPath according to Performance Measure Validation Protocol
- DMA contract with WellPath Select, Inc. Appendix V, "Statistical Reporting Requirements"
- Case Management: Children With Special Health Care Needs Policy # UR-227.3
- IPANC CSHCN Log 2005
- Onsite, phone interview with several WellPath personnel

VALIDATION FINDING

FC = **FULLY COMPLIANT**
Measure was fully compliant with DMA specifications

SC = **SUBSTANTIALLY COMPLIANT**
Measure was substantially compliant with DMA specifications and had only minor deviations that did not significantly bias the reported rate

NV = **NOT VALID**
Measure deviated from DMA specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required

NA = **NOT APPLICABLE**
Measure was not reported because WellPath did not have any Medicaid enrollees that qualified for the denominator

AUDIT DESIGNATION	=	FC

MPRO

PERFORMANCE MEASURMENT VALIDATION WORKSHEET

PERFORMANCE MEASURE:	Sterilizations Paid By Plan

METHODOLOGY FOR CALCULATING MEASURE: (check one)	☒ Administrative ☐ Hybrid ☐ Medical Record

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes	☒	☐	☐	Tab 9 in WellPath document binder contains all the appropriate data sources, program logic and source codes.
DENOMINATOR					
1. Population	Medicaid population appropriately segregated from commercial/Medicare	☒	☐	☐	P1 carrier field indicates the WellPath Medicaid population. Query step 3 used to determine the denominator for Sterilizations Paid by Plan indicates the use of P1
2. Geographic Area	Includes only Medicaid enrollees served in Mecklenburg County	☒	☐	☐	See above.
3. Age & Sex	All and both genders were considered	☒	☐	☐	Neither age nor sex were specified or excluded for this measure.
4. Enrollment Calculation	All enrollees considered	☒	☐	☐	P1 carrier field indicates the WellPath Medicaid population. Query step 3 used to determine the denominator for Sterilizations Paid by Plan indicates the use of P1
5.Data Quality	Based on the IS process audit findings, are any of the data sources for this denominator inaccurate?	☒	☐	☐	WellPath uses Health Trio Xpress as its data sources for this measure.

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
6. Proper Exclusion Methodology in Administrative Data (if no Exclusions were taken, check NA)	Only members with contraindications or data errors may be excluded. Contraindication exclusions are allowed only as per current State specifications Only the codes listed in specifications are counted as contraindications	☒	☐	☐	Contraindications are all specified under Query Step 3.
NUMERATOR					
7. Administrative Data: Counting Clinical Events	Utilize the standard codes listed in specifications or properly map internally developed codes. Members are counted only once; double counting of sterilizations was prevented	☒	☐	☐	The date that the plan receives the claim is the start date used to submit claims to DMA within 45 calendar days. Coding reflects prevention of duplicates and the use of standard codes.
8. Medical Review Documentation Standards		☐	☐	☒	Medical Record Review was not used for this measure.
9. Time Period	Sterilizations performed on Medicaid members that have been paid by the Plan between 1/1/05 & 12/31/05	☒	☐	☐	Query step 3 indicates coding that determines when the claim was received by the MCO, not when it was paid by the plan. (Reference: Tab 9 of the WellPath documentation entitled, "Sterilization Report Specifications")
10. Data Quality	Properly identify enrollees	☒	☐	☐	
SAMPLING	IF ADMINISTRATIVE METHOD WAS USED, CHECK N/A FOR AUDIT ELEMENTS 11, 12 AND 13				
11. Unbiased Sample	• Systematic sampling method is utilized	☐	☐	☒	Sampling was not used for this measure.

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
12. Sample Size	• After exclusions, sample size is equal to (1) the appropriate reduced sample size, which used the current year's administrative rate pr preceding year's report rate, (2) the total population	☐	☐	☒	Sampling was not used for this measure.
13. Proper Substitution Methodology in Medical Record Review (If no exclusions were taken, check NA)	• Only exclude members for whom medical record review revealed (1) contraindications that correspond to the codes listed in appropriate specifications or (2) data errors. • Substitutions are made for properly excluded records and the percentage of substituted records was documented	☐	☐	☒	Sampling was not used for this measure.

ADDITIONAL QUESTIONS

QUESTIONS	YES	NO
Were members excluded for contraindications found in the administrative data?	☒	☐
Were members excluded for contraindications found during the medical record review?	☐	☒
Were internally developed codes used?	☐	☒
What range defines the impact of data incompleteness for this measure (Check one)		
0 - 5 percentage points		☐
>5 - 10 percentage points		☐
>10 - 20 percentage points		☐
>20 - 40 percentage points		☐
>40 percentage points		☐
Unable to determine		☒
What is the direction of the bias? Check one: **No bias found in the review.**	☐Over-Reporting ☐Under-Reporting	

COMMENTS

- WellPath coding determined only those claims that were paid within the reporting period were considered based on the corrective action plan in the previous year.

Upon what documentation is the above percentage based? (e.g., internal reports, studies, comparison to medical records, etc.)

COMMENTS:

- Tab 9 of the WellPath documentation entitled, "Sterilization Report Specifications"
- Performance Measures list provided by WellPath according to Performance Measure Validation Protocol
- DMA contract with WellPath Select, Inc. Appendix V, "Statistical Reporting Requirements"
- Onsite, phone interview with WellPath personnel.

VALIDATION FINDING

FC = **FULLY COMPLIANT**
Measure was fully compliant with DMA specifications

SC = **SUBSTANTIALLY COMPLIANT**
Measure was substantially compliant with DMA specifications and had only minor deviations that did not significantly bias the reported rate

NV = **NOT VALID**
Measure deviated from DMA specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required

NA = **NOT APPLICABLE**
Measure was not reported because WellPath did not have any Medicaid enrollees that qualified for the denominator

AUDIT DESIGNATION	=	FC

MPRO

PERFORMANCE MEASURMENT VALIDATION WORKSHEET

PERFORMANCE MEASURE:	Hysterectomies Paid By Plan

METHODOLOGY FOR CALCULATING MEASURE: (check one)	☒ Administrative ☐ Hybrid ☐ Medical Record

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes	☒	☐	☐	Tab 8 in WellPath document binder contains all the appropriate data sources, program logic and source codes.
DENOMINATOR					
1. Population	Medicaid population appropriately segregated from commercial/Medicare	☒	☐	☐	P1 carrier field indicates the WellPath Medicaid population. Query step 3 used to determine the denominator for Hysterectomies Paid by Plan indicates the use of P1.
2. Geographic Area	Includes only Medicaid enrollees served in Mecklenburg County	☒	☐	☐	See Denominator 1.Population
3. Age & Sex	All ages Only females selected	☒	☐	☐	Age was not specified/excluded for this measure. Although sex should only include females, internal control measures within Health Trio Express prevent the inclusion of claims.
4. Enrollment Calculation	All female enrollees considered	☒	☐	☐	P1 carrier field indicates the WellPath Medicaid population. Query step 3 used to determine the denominator for Hysterectomies Paid by Plan indicates the use of P1.

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
5.Data Quality	Based on the IS process audit findings, are any of the data sources for this denominator inaccurate? Properly identified enrollees	☒	☐	☐	WellPath uses Health Trio Express as its data sources for this measure.
6. Proper Exclusion Methodology in Administrative Data (if no Exclusions were taken, check NA)	Only members with contraindications or data errors may be excluded. Contraindication exclusions are allowed only as per current State specifications Only the codes listed in specifications defined by State are counted as contraindications	☐	☐	☒	There are no exclusion criteria for these measures.
NUMERATOR					
7. Administrative Data: Counting Clinical Events	Standard codes or properly map all internally developed codes were used. Members are counted only once; double counting of hysterectomies is prevented	☒	☐	☐	The date that the plan receives the claim is the start date used to submit claims to DMA within 45 calendar days. Coding reflects prevention of duplicates and the use of standard codes.
8. Medical Review Documentation Standards		☐	☐	☒	
9. Time Period	Hysterectomies performed on Medicaid members that have been paid by the Plan between 1/1/05 & 12/31/05	☒	☐	☐	Query step 3 indicates coding that determines when the claim was received by the MCO, not when it was paid by the plan. (Reference: Tab 8 of the WellPath documentation entitled, "Hysterectomy Report Specifications")

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
10. Data Quality	Based on the IS process audit findings, are any of the data sources for this denominator inaccurate? Properly identified enrollees	☒	☐	☐	WellPath uses Health Trio Express as its data sources for this measure.
SAMPLING	IF ADMINISTRATIVE METHOD WAS USED, CHECK N/A FOR AUDIT ELEMENTS 11, 12 AND 13				
11. Unbiased Sample	Systematic sampling method is utilized	☐	☐	☒	Sampling was not used for this measure.
12. Sample Size	After exclusions, sample size is equal to (1) the appropriate reduced sample size, which used the current year's administrative rate pr preceding year's report rate, (2) the total population	☐	☐	☒	Sampling was not used for this measure.
13. Proper Substitution Methodology in Medical Record Review (If no exclusions were taken, check NA)	Only exclude members for whom medical record review revealed (1) contraindications that correspond to the codes listed in appropriate specifications or (2) data errors. Substitutions are made for properly excluded records and the percentage of substituted records was documented	☐	☐	☒	Sampling was not used for this measure.

ADDITIONAL QUESTIONS

QUESTIONS	YES	NO
Were members excluded for contraindications found in the administrative data?	☒	☐
Were members excluded for contraindications found during the medical record review?	☐	☒
Were internally developed codes used?	☐	☒
What range defines the impact of data incompleteness for this measure (Check one)		
0 - 5 percentage points		☐
>5 - 10 percentage points		☐
>10 - 20 percentage points		☐
>20 - 40 percentage points		☐
>40 percentage points		☐
Unable to determine		☒

What is the direction of the bias? Check one: **No bias found in the review.**	☐ Over-Reporting ☐ Under-Reporting

COMMENTS:

- WellPath coding determined only those claims that were paid within the reporting period were considered based on the corrective action plan in the previous year.

Upon what documentation is the above percentage based? (e.g., internal reports, studies, comparison to medical records, etc.)

COMMENTS:

- Tab 8 of the WellPath documentation entitled, "Hysterectomy Report Specifications"
- Performance Measures list provided by WellPath according to Performance Measure Validation Protocol
- DMA contract with WellPath Select, Inc. Appendix V, "Statistical Reporting Requirements"
- * Onsite, phone interview with WellPath personnel.

VALIDATION FINDING

FC = **FULLY COMPLIANT**
Measure was fully compliant with DMA specifications

SC = **SUBSTANTIALLY COMPLIANT**
Measure was substantially compliant with DMA specifications and had only minor deviations that did not significantly bias the reported rate

NV = **NOT VALID**
Measure deviated from DMA specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required

NA = **NOT APPLICABLE**
Measure was not reported because WellPath did not have any Medicaid enrollees that qualified for the denominator

AUDIT DESIGNATION	=	FC

Appendix C – Piedmont Performance Improvement Project Validation Report
(Amended 11/06/06)

Introduction

MPRO conducted an independent external quality review of Piedmont Behavioral Healthcare (PBH) in accordance with the Balanced Budget Act of 1997. The primary purpose of the audit was to validate PBH's performance improvement projects (PIPs) using the protocol titled *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities.* The results of this audit are written in this report.

The review was performed in four steps. The first step was a desk review of documents submitted to MPRO by PBH on August 1, 2006. The second step occurred when MPRO, along with State representatives, met at PBH for a face to face assessment of their compliance with the regulatory requirements. The onsite visit occurred on August 31, 2006. Following the onsite, DMA agreed to allow PBH to re-submit the PIPs for additional desk evaluation. The results of MPRO's review showed the following findings: Improving resolution of complaints within established guidelines- Confidence in reported MCO PIP results and Improving Coordination of Care and Reducing Recidivism Rates in State Facilities- Low Confidence in reported MCO PIP results. Then as suggested by MPRO, PBH submitted a corrective action plan with updated PIP reports on October 31, 2006. MPRO reviewed these PIPs and the findings contained within this report reflect the submitted changes.

The findings are now as follows:

Study Topic	Findings
Improving resolution of complaints within established guidelines	**Confidence** in reported MCO PIP results.
Improving Coordination of Care and Reducing Recidivism Rates in State Facilities	**Low Confidence** in reported MCO PIP results. **11/06/06 Amended:** **Confidence** in reported MCO PIP results.

The following sections include the validation worksheet for each PIP with MPRO's final comments and recommendations.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION WORKSHEET

Date(s) of evaluation: 08/15/06, 9/20/06, 10/31/06
On-site Review: 08/31/06
Final Report: 09/27/06
Amended 11/06/06

Demographic Information	
MCO Name:	**Piedmont Behavioral Healthcare**
Project Leader Name:	**Darlene Steele**
Telephone Number / E-mail Address:	**(704) 721-7000 / darlenes@pamh.com**
Name of Performance Improvement Project:	**Increasing the Number of Complaints Resolved Within a Thirty Day Time Period**
Dates of Study Period:	**04/01/2005 to 12/31/2005**
Documents Reviewed:	**Conducting Performance Improvement Project Summary – Non-clinical Improvement Project: Improving resolution of complaints within established guidelines.**

Type of Delivery System (check all that are applicable)			
☐ Staff Model	☐ MCO	Number of Medicaid Enrollees in MCO or PIHP:	**79,357**
☐ Network	☒ PIHP	Number of Medicaid/Medicare Dual Eligible Enrollees in MCO or PIHP:	**2.017**
☐ Direct IPA		Number of Medicaid Enrollees in Study:	**79,357**
☐ IPA Organization		Total Number of MCO or PIHP Enrollees in Study:	**79,357**
(Identify Delivery System above for MCO)			
Number of MCO/PIHP primary care physicians: NA			
Number of MCO/PIHP specialty physicians: NA			
Number of physicians in study: 603			

I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1. REVIEW THE SELECTED STUDY TOPIC(S)

Component/Standard	Y	N	N/A	Comments
1.1- Was the topic selected through data collection and analysis of comprehensive aspect of enrollee needs, care and services?	☒	☐	☐	Piedmont selected the non-clinical topic "Improving the percentage of complaints handled and resolved within the thirty day guideline" as its targeted improvement project. The narrative establishes the selection of the study topic that is based on feedback from consumers, providers and stakeholders. Need to quantify the number (percentage) of consumers, provider and PBH components who rated complaints as a high priority for receiving "report card" information. The study focus also seeks to improve the current complaint process so that complaints are handled appropriately, systematically and to track and trend issues within the PBH network. There is no reference to the collection of data to substantiate the need for the study. Recommendation: Insert baseline data in the summary along with the results. Add additional sources of information and/or literature reviews to support the study relevance to the Medicaid population. In addition, demonstrate the link between consumer satisfaction and improving the turn around time for resolving and reducing the number of complaints. Expand the narrative to include how often complaints are monitored at PBH, who is responsible for this process, what committee monitors the process and how often are the results reported. **Final Assessment:** The PIP report was updated to include baseline data and study selection criteria.

Component/Standard	Y	N	N/A	Comments
1.2- Did the MCO's PIPs over time address a broad spectrum of key aspects of enrollee care and services?	☒	☐	☐	The focus of the study over time emphasizes an improvement in the process for resolving complaints received by PBH.
1.3- Did the MCO's PIPs over time include all enrolled populations; i.e., did not exclude certain enrollees such as those with special health care needs?	☒	☐	☐	The study includes all consumers who issue a complaint through PBH. Recommendation: Insert a statement reinforcing that this population includes consumers with special health needs. **Final Assessment:** The PIP report was updated to include a statement that this project includes consumers with special health needs.

Step 2: REVIEW THE STUDY QUESTION(S)				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
2.1- Was/were the study question(s) stated clearly in writing?	☒	☐	☐	The study question as stated asks, "Will improving the process for managing complaints ensure that PBH handles and resolves 80% of complaints within the mandated thirty day guideline? " The goal of the study is to resolve 80% of the complaints within 30-day as specified by contractual guidelines. Recommendation: Based on the results of the analysis of the baseline data, determine a quantifiable goal for the study such as an X% improvement in processing complaints within 30-days. Identify the sources of data used to form the study question, i.e., describe what data is pulled, from what sources, how often the data is pulled and to whom the data is reported. **Final Assessment:** The PIP has been updated to reflect a quantifiable rate of improvement. Section 1.1 identifies the sources of data used to be from a complaints database.

Step 3: REVIEW SELECTED STUDY INDICATOR(S)

Component/Standard	Y	N	N/A	Comments
3.1- Did the study use objective, clearly defined, measurable indicators?	☒	☐	☐	The study description does not clearly define the study indicators or how they will measure process improvements. Need to expand narrative in quantitative and qualitative terms such as explaining the numerator, denominator and measurement time frame for each indicator. **Final Assessment:** The PIP has been updated to include timeframes for data collection, definitions of the indicators to be analyzed, potential barriers, and section 6.1 describes how the indicators will be analyzed.
3.1(a) – Was/were the indicator(s) related to identified health care guidelines pertinent to the study question?	☐	☐	☒	The study topic is non-clinical.
3.1(b) – Was this an important aspect of care to monitor that made a difference to the MCO's / PIHP's beneficiaries?	☒	☐	☐	The study narrative makes the assumption that by improving the process of resolving complaints it will in turn improve consumer and provider satisfaction.
3.1I – Were the data available either through administrative data, medical records or other readily accessible sources?	☒	☐	☐	Need to specify the database for tracking complaints and describe its characteristics and capabilities. **Final Assessment:** Section 6.1 describes the database characteristics and capabilities.
3.1(d) – Did limitations on the ability to collect the data skew the results?	☒	☐	☐	No data provided. Need to describe if there are any challenges in the complaint resolution process that may skew the results, i.e., difficulty with customer service representatives coding complaints. **Final Assessment:** The PIP has been updated to include potential barriers.
3.1(e) – Did these indicators require explicit or implicit criteria?	☒	☐	☐	Once the indicator description is expanded, it will contain clear and understandable criteria.

Component/Standard	Y	N	N/A	Comments
				Final Assessment: The PIP has been updated to include clear and understandable criteria.
3.2- Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	☒	☐	☐	Indicators will measure changes in the process of resolving complaints.

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
4.1- Did the MCO clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	☒	☐	☐	The study identifies that all complaints received by PBH will be monitored. Recommendation: Need to also expand the narrative to include information on the study periods.
4.2- If the MCO studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?	☒	☐	☐	Study identifies that the data captures all consumers, family members, stakeholders, providers and community members who have filed a complaint.

Step 5: REVIEW SAMPLING METHODS				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
5.1- Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	☐	☐	☒	No sampling techniques were employed.
5.2- Did the MCO employ valid sampling techniques that protected against bias? *Specify the type of sampling or census used:*	☐	☐	☒	
5.3- Did the sample contain a sufficient number of enrollees?	☐	☐	☒	

Step 6: REVIEW DATA COLLECTION PROCEDURES

Component/Standard	Y	N	N/A	Comments
6.1- Did the study design clearly specify the data to be collected?	☒	☐	☐	Describe who will be entering the data into the complaint database, i.e. customer service representative, clinical staff or provider representatives. Add information on how the process is tracked through PBH. Additional information is needed to identify how the measures will be analyzed and who receives the reports i.e., monitoring process outcomes monthly and whether reported to the QM committee and DMA? **Final Assessment:** The PIP has been updated to include the staff who will be entering data, how the data will be analyzed, the frequency of the analysis, and to who the information will be reported to.
6.2- Did the study design clearly specify the sources of data?	☒	☐	☐	The sources of data are described in the narrative. Recommendation: Specify the date ranges for collecting the data. **Final Assessment:** The PIP has been updated to include date ranges for collecting data.
6.3- Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒	☐	☐	The study identified a systematic method of collecting data that represents the entire relevant population.
6.4- Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	☒	☐	☐	Data collection is performed through queries into the PBH complaint database. Explain the display format of the report used to collect data to emphasis the consistency and accuracy over time.
6.5- Did the study design prospectively specify a data analysis plan?	☒	☐	☐	Need to expand the data analysis plan to describe how the data will be analyzed. **Final Assessment:** The PIP has been updated describing how the data will be analyzed.

Component/Standard	Y	N	N/A	Comments
6.6- Were qualified staff and personnel used to collect the data?	☒	☐	☐	Qualified staff are used to collect the data.

Step 7: ASSESS IMPROVEMENT STRATEGIES				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
7.1- Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	☒	☐	☐	Study interventions need to be placed in chronological order. Describe what committee is monitoring the process. Do you need to track turnaround time monthly? Need to identify what actions steps will be taken to address barriers. Recommendation: Interventions need to be implemented after the baseline measurement time period. **Final Assessment:** The PIP has been updated to include a description of interventions in chronological order including potential future interventions.

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
8.1- Was an analysis of the findings performed according to the data analysis plan?	☐	☐	☒	
8.2- Did the MCO present numerical PIP results and findings accurately and clearly?	☐	☐	☒	
8.3- Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	☐	☐	☒	
8.4- Did the analysis of study data include an interpretation of the extent to which its PIP was successful and the follow-up activities?	☐	☐	☒	

Step 9: ASSESS WHETHER IMPROVEMENT IS REAL IMPROVEMENT				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
9.1- Was the same methodology as the baseline measurement used, when measurement was repeated?	☐	☐	☒	
9.2- Was there any documented, quantitative improvement in processes or outcomes of care?	☐	☐	☒	
9.3- Does the reported improvement in performance have "face" validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	☐	☐	☒	
9.4- Is there any statistical evidence that any observed performance improvement is true improvement?	☐	☐	☒	

Step 10: ASSESS SUSTAINED IMPROVEMENT				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
10.1- Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐	☐	☒	

ACTIVITY 2. VERIFYING STUDY FINDINGS (OPTIONAL)				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
1. Were the initial study findings verified upon repeat measurements?	☐	☐	☒	

ACTIVITY 3. EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY				
	Y	**N**	**N/A**	
Totals	19	0	14	

Preliminary Assessment:

The study narrative represents the start of a good study foundation as currently written. Need to expand the narrative to provide the reader with sufficient information to evaluate the validity and reliability of the study.

9-19-06 Final Assessment:

The PIP worksheet has been updated to include all recommendations documented in the desk review and discussed during the onsite visit. It is recommended that the information described in the worksheets be transferred into a final narrative report. This report can then be utilized for education and as a marketing tool.

11-06-06 Amendment:

The updated report received on 10-31-06 is now in a narrative report form as recommended by MPRO.

Check one:	☐ High confidence in reported MCO PIP results ☒ Confidence in reported MCO PIP results ☐ Low confidence in reported MCO PIP results ☐ Reported MCO PIP results not credible

PERFORMANCE IMPROVEMENT PROJECT VALIDATION WORKSHEET

Date(s) of evaluation: 08/14/06, 09/20/06, 10/31/06
On-site Review: 08/31/06
Final Report: 09/27/06
Amended 11/06/06

Demographic Information	
MCO Name:	**Piedmont Behavioral Healthcare**
Project Leader Name:	**Darlene Steele**
Telephone Number / E-mail Address:	**(704) 721-7000 / darlenes@pamh.com**
Name of Performance Improvement Project:	**Improve Continuity of Care and Reduce Recidivism Rates in State Facilities**
Dates of Study Period:	**04/01/2005 to 12/31/2005**
Documents Reviewed:	**Conducting Performance Improvement Project Summary – Improving Coordination of Care and Reducing Recidivism Rates in State Facilities.**

Type of Delivery System (check all that are applicable)			
☐ Staff Model	☐ MCO	Number of Medicaid Enrollees in MCO or PIHP:	**79,357**
☐ Network	☒ PIHP	Number of Medicaid/Medicare Dual Eligible Enrollees in MCO or PIHP:	**2.017**
☐ Direct IPA		Number of Medicaid Enrollees in Study:	**79,357**
☐ IPA Organization		Total Number of MCO or PIHP Enrollees in Study:	**79,357**
(Identify Delivery System above for MCO)			
Number of MCO/PIHP primary care physicians: NA			
Number of MCO/PIHP specialty physicians: NA			
Number of physicians in study: 603			

I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1. REVIEW THE SELECTED STUDY TOPIC(S)

Component/Standard	Y	N	N/A	Comments
1.1- Was the topic selected through data collection and analysis of comprehensive aspect of enrollee needs, care and services?	☒	☐	☐	Piedmont selected the clinical topic "Improving continuity of care and reducing recidivism rates in State facilities through the involvement of the Screening Triage and Referral (STR) Department via discharge planning as its targeted improvement project. The study focus is to reduce recidivism by moving a consumer from a higher level of inpatient care through discharge planning, to where supports and services can be utilized to continue care. There is no reference to the data collection to support the need for the study. Recommendation: Insert baseline data in the summary along with the results. Add additional sources of information and/or literature reviews to support the study relevance. Describe demographic characteristics of consumers impacted by the study. Describe in more detail what are the risks or potential consequences of continuing the current process. **Final Assessment:** Although the PIP has been updated to include data on the new detox. facility, complete baseline data is not included. Example: How many enrollees are affected by either crisis or substance abuse services per year? How many enrollees are referred to emergency departments and/or inpatient hospitals per year for crisis intervention? **Amendment:** Baseline data was included in the updated report received on 10-31-06.

Component/Standard	Y	N	N/A	Comments
1.2- Did the MCO's PIPs over time address a broad spectrum of key aspects of enrollee care and services?	☒	☐	☐	The clinical focus of the study over time addresses inpatient admissions and emphasizes continuity of care for consumers in crisis.
1.3- Did the MCO's PIPs over time include all enrolled populations; i.e., did not exclude certain enrollees such as those with special health care needs?	☒	☐	☐	The study includes all consumers who are admitted and/or discharged from an inpatient hospitalization. Recommendation: Insert a statement reinforcing that this population includes consumers with special health needs. **Final Assessment:** The PIP report has been updated to include a statement that this project includes consumers with special health needs.

Step 2: REVIEW THE STUDY QUESTION(S)

Component/Standard	Y	N	N/A	Comments
2.1- Was/were the study question(s) stated clearly in writing?	☒	☐	☐	The study question clearly asks, "Does the involvement of the STR Department through the discharge planning process improve continuity of care and reduce recidivism rates in state facilities? " However, the study questions needs to quantify a study goal. Recommendation: Based on the results of an analysis of the baseline data determine a quantitative goal for the study such as an X% decrease in recidivism rates. Expand the narrative to describe what specific data is pulled from the administrative claims database. **Final Assessment:** The PIP report has been updated to include a quantifiable rate of improvement and the source of data to be administrative claims data.

Step 3: REVIEW SELECTED STUDY INDICATOR(S)

Component/Standard	Y	N	N/A	Comments
3.1- Did the study use objective, clearly defined, measurable indicators?	☒	☐	☐	The study description does not clearly define the study indicators or how they will measure outcomes of care. Need to expand narrative in quantitative and qualitative terms such as explaining the numerator, denominator and measurement time frame for each indicator. **Final Assessment:** The PIP report has been updated to include objective, clearly defined, and measurable indicators.
3.1(a) – Was/were the indicator(s) related to identified health care guidelines pertinent to the study question?	☒	☐	☐	Need to provide information on how the indicators are related to health care guidelines and/or whether they have been piloted or field-tested. **Final Assessment:** The updated PIP report does not include the relationship of the indicators with health care guidelines. **Amendment:** The updated report received on 11-01-06 indicates that the indicators are specific to PBH.
3.1(b) – Was this an important aspect of care to monitor that made a difference to the MCO's / PIHP's beneficiaries?	☒	☐	☐	The study supports the need to improve care provided to consumers by preventing an inpatient re-admission.
3.1(c) – Were the data available either through administrative data, medical records or other readily accessible sources?	☒	☐	☐	Data will be collected from an administrative claims database.
3.1(d) – Did limitations on the ability to collect the data skew the results?	☒	☐	☐	No data was provided The study identifies that State hospitals bill through invoices not claims which can limit the accuracy of the data however; follow-up by the STR Department will improve the completeness of the data.

Component/Standard	Y	N	N/A	Comments
				Final Assessment: The updated PIP report still does not include data to support the health plan's statement indicated above. **Amendment:** The updated report indicates that 'much of the inpatient data will come from claims. However, state hospitals bill via invoices, not claims. However, follow up by the STR Department will improve the completeness of the data.'
3.1(e) – Did these indicators require explicit or implicit criteria?	☒	☐	☐	Once the indicator description is expanded the criteria will become clear and understandable. **Final Assessment:** The indicators have been updated are clear and understandable.
3.2- Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	☒	☐	☐	Indicators will measure changes in continuity of care due to involvement with the STR Department through discharge planning.

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
4.1- Did the MCO clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	☒	☐	☐	Recommendation: Expand the narrative to include a description of the study population, i.e., ages, diagnosis codes, enrollment requirements if applicable, what services are monitored after discharge, average lengths of stay, and number of participating facilities. Include information on the current recidivism rates.
4.2- If the MCO studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?	☒	☐	☐	The study identifies that the data captures all consumers who have received services from behavioral health and substance abuse inpatient and facility based crisis centers.

Step 5: REVIEW SAMPLING METHODS				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
5.1- Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	☐	☐	☒	All consumers in the study who received identified services were used. No sampling techniques were employed.
5.2- Did the MCO employ valid sampling techniques that protected against bias? *Specify the type of sampling or census used:*	☐	☐	☒	
5.3- Did the sample contain a sufficient number of enrollees?	☐	☐	☒	

Step 6: REVIEW DATA COLLECTION PROCEDURES				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
6.1- Did the study design clearly specify the data to be collected?	☒	☐	☐	Describe how process measures will be monitored and used, i.e., automated through data collection. Additional information is needed to identify how the measures will be analyzed i.e., comparing recidivism outcomes of care for consumers admitted to an inpatient facility to consumers admitted to a crisis recovery center. **Final Assessment:** The PIP report has been updated to include the types of reports to be run for data collection.
6.2- Did the study design clearly specify the sources of data?	☒	☐	☐	The sources of data are described in the narrative. Recommendation: Specify the date ranges for collecting the data. **Final Assessment:** The updated PIP report still does not include date ranges for collecting the data. Amendment: The updated report now includes date ranges for collecting the data.

Component/Standard	Y	N	N/A	Comments
6.3- Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒	☐	☐	The study identified a systematic method of collecting data that represents the entire relevant population.
6.4- Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	☒	☐	☐	Data collection is performed through claims, enrollment, and encounter data, invoices, treatment authorizations, referrals, state hospital data, Crisis Recovery Center data and STR follow-up data. Need to provide information on the steps taken to ensure the process is consistent and collects accurate data over time. Need to provide information on interrater reliability audits if applicable. Study narrative indicates no data collection tools were used. **Final Assessment:** The PIP report has been updated to include the processes utilized to ensure consistency in data collection.
6.5- Did the study design prospectively specify a data analysis plan?	☒	☐	☐	The data analysis plan is specified.
6.6- Were qualified staff and personnel used to collect the data?	☒	☐	☐	Qualified staff is used to collect the data.

Step 7: ASSESS IMPROVEMENT STRATEGIES				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
7.1- Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	☒	☐	☐	Study interventions need to be placed in chronological order. Need to identify barriers and what actions steps will be taken. Recommendation: Interventions need to be implemented after the baseline measurement time period. **Final Assessment:** No changes were made to the updated PIP report. **Amendment:** The updated report describes the interventions and places them in chronological order.

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
8.1- Was an analysis of the findings performed according to the data analysis plan?	☐	☐	☒	
8.2- Did the MCO present numerical PIP results and findings accurately and clearly?	☐	☐	☒	
8.3- Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	☐	☐	☒	
8.4- Did the analysis of study data include an interpretation of the extent to which its PIP was successful and the follow-up activities?	☐	☐	☒	

Step 9: ASSESS WHETHER IMPROVEMENT IS REAL IMPROVEMENT				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
9.1- Was the same methodology as the baseline measurement used, when measurement was repeated?	☐	☐	☒	
9.2- Was there any documented, quantitative improvement in processes or outcomes of care?	☐	☐	☒	
Component/Standard	**Y**	**N**	**N/A**	**Comments**
9.3- Does the reported improvement in performance have “face” validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	☐	☐	☒	
9.4- Is there any statistical evidence that any observed performance improvement is true improvement?	☐	☐	☒	

Step 10: ASSESS SUSTAINED IMPROVEMENT				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
10.1- Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐	☐	☒	

ACTIVITY 2. VERIFYING STUDY FINDINGS (OPTIONAL)				
Component/Standard	**Y**	**N**	**N/A**	**Comments**
1. Were the initial study findings verified upon repeat measurements?	☐	☐	☒	

ACTIVITY 3. EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

	Y	**N**	**N/A**	
Totals	20	0	13	

Preliminary Assessment:

The study narrative represents the start of a good study foundation as currently written. Need to set quantifiable goals and to expand the narrative to provide the reader with sufficient information to evaluate the validity and reliability of the study.

Final Assessment and Recommendations:

The PIP report has not been updated with all the recommendations documented in the desk review and discussed during the onsite visit. The following are outstanding recommendations and are imperative to ensuring validity and reliability of the study.

- (1.1) Insert baseline data in the summary along with the results. Add additional sources of information and/or literature reviews to support the study relevance. Describe demographic characteristics of consumers impacted by the study. Describe in more detail what are the risks or potential consequences of continuing the current process.
- (3.1) (a) Provide information on how the indicators are related to health care guidelines and/or whether they have been piloted or field-tested.
- (3.1) (d) Provide data that supports the statement that because the State hospitals bill through invoices not claims can limit the accuracy of the data
- (6.2) Specify the date ranges for collecting the data.
- (7.1) Place study interventions in chronological order, identifying barriers with documented interventions to address these barriers.

It is also recommended that the information described in the worksheets be transferred into a final narrative report. This report can then be utilized for education and as a marketing tool.

11-6-06 Amendment:

The report has been updated with all the recommendations and is now in a narrative report form. MPRO now finds 'Confidence' in the reported PIP.

Check one:	☐ High confidence in reported MCO PIP results ☒ Confidence in reported MCO PIP results ☐ Low confidence in reported MCO PIP results ☐ Reported MCO PIP results not credible

Appendix D – Piedmont Performance Measure Validation Report

(Amended 10/26/06)

Introduction

MPRO conducted an independent external quality review of Piedmont Behavioral Healthcare in accordance with the Balanced Budget Act of 1997. The primary purpose of the audit was to validate Piedmont's Performance Measures (PMs) using the protocol titled *Validating Performance Measures: A Protocol for Use in Conducting Medicaid External Quality Review Activities.* The results of this audit are written in this report. The validation activities address:

1. Review of the data management processes of the MCO;
2. Evaluation of algorithmic compliance (the translation of captured data into actual statistics) with specifications defined by the State; and
3. Verification of either the entire set or a sample of the State-specified performance measures to confirm that the reported results are based on accurate sources of information.

The review was performed in three steps. The first step was a desk top review of documents submitted to MPRO by Piedmont on July 31st, 2006. The second step occurred when MPRO along with State representatives met at Piedmont for a face to face assessment of their compliance to the regulatory requirements. The onsite visit occurred on August 31st, 2006. During the onsite review, Piedmont provided clarification and information related to the Performance Measures as well as their information systems capabilities. The third step was when Piedmont supplied MPRO with additional information on September 18th as follow up to questions from the onsite review. MPRO validated seven performance measures: Follow-up After Hospitalization for Mental Illness; Mental Health Utilization; Chemical Dependency Utilization; Number of Consumers Moved from Institutional Care to Community Care; Initiation and Engagement of Alcohol and Other Drug Dependence Treatment; Utilization Management of the Provision of High Use Services; and Complaints/Grievances/Appeals.

There are four possible validation findings for each performance measure as defined below.

POSSIBLE VALIDATION FINDINGS		
FC	=	**FULLY COMPLIANT** Measure was fully compliant with DMA specifications
SC	=	**SUBSTANTIALLY COMPLIANT** Measure was substantially compliant with DMA specifications and had only minor deviations that did not significantly bias the reported rate
NV	=	**NOT VALID** Measure deviated from DMA specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required
NA	=	**NOT APPLICABLE** Measure was not reported because Piedmont did not have any Medicaid enrollees that qualified for the denominator

Summary of Findings

On October 26, 2006 MPRO, Piedmont, and DMA had a conference call and Piedmont indicated that members cannot be disenrolled. Because of this, two of the performance measures were updated to 'Full Compliance'. The findings of the performance measure validation activity are now as follows:

Measure	Findings
Follow-up After Hospitalization for Mental Illness	**SC** - Measure was **substantially compliant** with DMA specifications and had only minor deviations that did not significantly bias the reported rate. **10/26/06 Amended:** **FC** - Measure was **fully compliant** with DMA specifications.
Mental Health Utilization	**FC** - Measure was **fully compliant** with DMA specifications.
Chemical Dependency Utilization	**FC** - Measure was **fully compliant** with DMA specifications.
Number of Consumers Moved from Institutional Care to Community Care	**FC** - Measure was **fully compliant** with DMA specifications.
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	**SC** - Measure was **substantially compliant** with DMA specifications and had only minor deviations that did not significantly bias the reported rate. **10/26/06 Amended:** **FC** - Measure was **fully compliant** with DMA specifications.
Utilization Management of the Provision of High Use Services	**FC** - Measure was **fully compliant** with DMA specifications.
Complaints/Grievances/Appeals	**FC** - Measure was **fully compliant** with DMA specifications.

All documentation relating to the Information Systems Capabilities Assessment is satisfactory.

The definitions for the compliance determinations are listed below.

DEFINITIONS	
Met:	The MCO's measurement and reporting process was fully compliant with State specifications.
Not Met:	The MCO's measurement and reporting process was not compliant with State specifications. This data element should be used for any audit element that deviates from the State specifications, regardless of the impact of the deviation on the final rate. All audit elements with this designation must include an explanation of the deviation in the comments section.
N/A:	The audit element was not applicable to the MCO's measurement and reporting process.

PERFORMANCE MEASURMENT VALIDATION WORKSHEET
(Amended 10/26/06)

PERFORMANCE MEASURE:	Follow-up After Hospitalization for Mental Illness

METHODOLOGY FOR CALCULATING MEASURE: (check one)	☒ Administrative ☐ Hybrid ☐ Medical Record

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes	☒	☐	☐	csp_report_INPfollow_28-1 specifies all codes.
DENOMINATOR					
1. Population	• Medicaid population appropriately segregated from commercial/Medicare • Population defined as effective Medicaid enrollment as of December 31, 2005	☒	☐	☐	Separate reports to be generated for (1) Medicaid (2) other. n-tiered model code incorporates the population specifications.
2. Geographic Area	• Includes only Medicaid enrollees served in specified counties	☒	☐	☐	Receives claims for these counties only
3. Age & Sex	• Age specified • All genders selected	☒	☐	☐	csp_report_INPfollow_28-1 specifies all codes, with age > 6years at the date of discharge.

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
4. Enrollment Calculation	• Were members of plan as of 12/31/05 • Were continuously enrolled for up to 30 days from date of discharge	☒	☐	☐	csp_report_INPfollow_28-1 specifies all codes. However, the programming logic does not incorporate continuous enrollment up to 30 days from date of discharge. MPRO recommends that the denominator be corrected to include this requirement. 10/26/06-Piedmont indicates that members can not be disenrolled.
5. Data Quality	• Based on the IS process audit findings, are any of the data sources for this denominator inaccurate?	☒	☐	☐	Piedmont uses claims that have been processed and approved for payment to the Great Plains Accounting System in batches. Claims passing from the CI system to the Great Plains AP Module are verified by the CI report entitled, "CI Invoice by Great Plains Batch", when the data transfer is completed.
6. Proper Exclusion Methodology in Administrative Data (if no Exclusions were taken, check NA)	• Exclusions were performed according to current specifications • Duplicate members identified with multiple date spans for eligibility are consolidated into one member record	☒	☐	☐	Exclusion criteria are applied appropriately. Queries used to determine the denominator removes duplicates.
NUMERATOR					
7. Administrative Data: Counting Clinical Events	• Standard codes listed in specifications or properly map internally developed codes were used • Members are counted only once; double counting of New Member Assessment was prevented	☒	☐	☐	Standard codes specified under Section III D.44 PI #28 Script. All members counted once with no double counting.

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
8. Medical Review Documentation Standards	Record abstraction tool required notation of the date that the New Member Assessment was performed	☐	☐	☒	Medical Record Review was not used for this measure.
9. Time Period	• All discharges in MH diagnoses group on or between 1/1/05 & 12/1/05. Must have ambulatory MH claim or intermediate treatment with a MH practitioner within 1/1/05 & 12/31/05	☒	☐	☐	Standard codes specified under Section III D.44 PI #28 Script defines the specifications.
10. Data Quality	• Properly identify enrollees • Based on the IS process audit findings, are any of the data sources used for this numerator inaccurate?	☒	☐	☐	Standard codes specified under Section III D.44 PI #28 Script defines the specifications. Data quality fairly accurate.
SAMPLING	IF ADMINISTRATIVE METHOD WAS USED, CHECK N/A FOR AUDIT ELEMENTS 11, 12 AND 13				
11. Unbiased Sample	• Systematic sampling method is utilized	☐	☐	☒	Sampling was not used for this measure.
12. Sample Size	• After exclusions, sample size is equal to (1) the appropriate reduced sample size, which used the current year's administrative rate pr preceding year's report rate, (2) the total population	☐	☐	☒	Sampling was not used for this measure.
13. Proper Substitution Methodology in Medical Record Review (If no exclusions were taken, check NA)	• Only exclude members for whom medical record review revealed (1) contraindications that correspond to the codes listed in appropriate specifications or (2) data errors. • Substitutions are made for properly excluded records and the percentage of substituted records was documented	☐	☐	☒	Sampling was not used for this measure.

ADDITIONAL QUESTIONS	YES	NO
Were members excluded for contraindications found in the administrative data?	☒	☐
Were members excluded for contraindications found during the medical record review?	☐	☒
Were internally developed codes used?	☒	☐

What range defines the impact of data incompleteness for this measure? (Check one)	
0 - 5 percentage points	☒
>5 - 10 percentage points	☐
>10 - 20 percentage points	☐
>20 - 40 percentage points	☐
>40 percentage points	☐
Unable to determine	☐

What is the direction of the bias? Check one:	☐Over-Reporting ☒Under-Reporting

COMMENTS
The percentage of data that is incomplete is so insignificant that it does not cause any alarm.

Upon what documentation is the above percentage based? (e.g., internal reports, studies, comparison to medical records, etc.)

COMMENTS:
Programming logic does not incorporate continuous enrollment up to 30 days from date of discharge. This might cause some bias in the estimated rate because not all Medicaid enrollees would then be eligible for the measure.

10/26/06- Piedmont indicates that members can not be disenrolled. Members will always either have Medicaid or State funding. In the future, Piedmont should develop a process to differentiate between the two populations: Medicaid and State funded.

VALIDATION FINDING

FC = **FULLY COMPLIANT**
Measure was fully compliant with DMA specifications

SC = **SUBSTANTIALLY COMPLIANT**
Measure was substantially compliant with DMA specifications and had only minor deviations that did not significantly bias the reported rate

NV = **NOT VALID**
Measure deviated from DMA specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required

NA = **NOT APPLICABLE**
Measure was not reported because Piedmont did not have any Medicaid enrollees that qualified for the denominator

AUDIT DESIGNATION	=	FC

MPRO

PERFORMANCE MEASURMENT VALIDATION WORKSHEET

PERFORMANCE MEASURE:	Mental Health Utilization

METHODOLOGY FOR CALCULATING MEASURE: (check one)	☒ Administrative ☐ Hybrid ☐ Medical Record

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes	☒	☐	☐	csp_report_utilzation_PF_29_30 specifies the programming code that includes this measure.
DENOMINATOR					
1. Population	• Medicaid population appropriately segregated from commercial/Medicare • Population defined as effective Medicaid enrollment as of December 31, 2005	☒	☐	☐	Separate reports to be generated for (1) Medicaid (2) other. N-tiered model code incorporates the population specifications.
2. Geographic Area	• Includes only Medicaid enrollees served in specified counties	☒	☐	☐	Receives claims for these counties only.
3. Age & Sex	• Members of all ages & sex	☒	☐	☐	csp_report_utilzation_PF_29_30 specifies all ages and sex.
4. Enrollment Calculation	• Were members of plan as of 12/31/05	☒	☐	☐	csp_report_utilzation_PF_29_30 specifies enrollment for this measure.

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
5. Data Quality	• Based on the IS process audit findings, are any of the data sources for this denominator inaccurate?	☒	☐	☐	Piedmont uses claims that have been processed and approved for payment to the Great Plains Accounting System in batches. Claims passing from the CI system to the Great Plains AP Module are verified by the CI report entitled, "CI Invoice by Great Plains Batch", when the data transfer is completed.
6. Proper Exclusion Methodology in Administrative Data (if no Exclusions were taken, check NA)	• Only members with contraindications or data errors may be excluded. • Contraindication exclusions are allowed only as per current State specifications • Only the codes listed in specifications are counted as contraindications	☐	☐	☒	Calculation of the measure does not involve the exclusion of contraindications.
NUMERATOR					
7. Administrative Data: Counting Clinical Events	• Members are counted only once; double counting of CSHCN is prevented	☒	☐	☐	Standard Codes specified under Section III D.4 PI #29; no double counting.
8. Medical Review Documentation Standards	Record abstraction tool required notation of the date that the CSHCN was performed	☐	☐	☒	Medical Record Review was not used for this measure.
9. Time Period	The number of members receiving any mental health services, inpatient mental health services, intermediate mental health services, and ambulatory mental health services during 1/1/2005 - 12/31/2005	☒	☐	☐	Standard Codes specified under Section III D.4 PI #29.

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
10. Data Quality	Properly identify enrollees	☒	☐	☐	Standard Codes specified under Section III D.4 PI #29 defines the specifications. Data quality fairly accurate.
SAMPLING	IF ADMINISTRATIVE METHOD WAS USED, CHECK N/A FOR AUDIT ELEMENTS 11, 12 AND 13				
11. Unbiased Sample	• Systematic sampling method is utilized	☐	☐	☒	Sampling was not used for this measure.
12. Sample Size	• After exclusions, sample size is equal to (1) the appropriately reduced sample size, which used the current year's administrative rate or preceding year's reported rate, or (2) the total population	☐	☐	☒	Sampling was not used for this measure.
13. Proper Substitution Methodology in Medical Record Review (If no exclusions were taken, check NA)	• Only exclude members for whom medical record review revealed (1) contraindications that correspond to the codes listed in appropriate specifications or (2) data errors. • Substitutions are made for properly excluded records and the percentage of substituted records was documented	☐	☐	☒	Sampling was not used for this measure.

ADDITIONAL QUESTIONS	YES	NO
Were members excluded for contraindications found in the administrative data?	☐	☒
Were members excluded for contraindications found during the medical record review?	☐	☒
Were internally developed codes used?	☐	☒

What range defines the impact of data incompleteness for this measure? (Check one)	
0 - 5 percentage points	☒
>5 - 10 percentage points	☐
>10 - 20 percentage points	☐
>20 - 40 percentage points	☐
>40 percentage points	☐
Unable to determine	☐
What is the direction of the bias? Check one:	☐Over-Reporting ☒Under-Reporting

COMMENTS
The percentage of data that is incomplete is so insignificant that it does not cause any alarm

Upon what documentation is the above percentage based? (e.g., internal reports, studies, comparison to medical records, etc.)

COMMENTS:
Internal reports (claims processing III.D.1) and PBHC software assessment summary logs.

VALIDATION FINDING

FC	=	**FULLY COMPLIANT** Measure was fully compliant with DMA specifications
SC	=	**SUBSTANTIALLY COMPLIANT** Measure was substantially compliant with DMA specifications and had only minor deviations that did not significantly bias the reported rate
NV	=	**NOT VALID** Measure deviated from DMA specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required
NA	=	**NOT APPLICABLE** Measure was not reported because Piedmont did not have any Medicaid enrollees that qualified for the denominator

AUDIT DESIGNATION = **FC**

MPRO

PERFORMANCE MEASURMENT VALIDATION WORKSHEET

PERFORMANCE MEASURE:	Chemical Dependency Utilization

METHODOLOGY FOR CALCULATING MEASURE: (check one)	☒ Administrative ☐ Hybrid ☐ Medical Record

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes	☒	☐	☐	csp_report_utilzation _PF_29_30 specifies the programming code that includes this measure.
DENOMINATOR					
1. Population	• Medicaid population appropriately segregated from commercial and Medicare. • Population defined as effective Medicaid enrollment as of December 31, 2005.	☒	☐	☐	Separate reports to be generated for (1) Medicaid (2) other. n-tiered model code incorporates the population specifications.
2. Geographic Area	• Includes only Medicaid enrollees served in specified counties	☒	☐	☐	Receives claims for these counties only.
3. Age & Sex	• Members of all ages & sex	☒	☐	☐	csp_report_utilzation _PF_29_30 specifies all ages and sex.
4. Enrollment Calculation	• Were members of plan as of 12/31/05	☒	☐	☐	csp_report_utilzation _PF_29_30 specifies enrollment for this measure.

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
5. Data Quality	• Based on the IS process audit findings, are any of the data sources for this denominator inaccurate?	☒	☐	☐	Piedmont uses claims that have been processed and approved for payment to the Great Plains Accounting System in batches. Claims passing from the CI system to the Great Plains AP Module are verified by the CI report entitled, "CI Invoice by Great Plains Batch", when the data transfer is completed.
6. Proper Exclusion Methodology in Administrative Data (if no Exclusions were taken, check NA)	• Only members with contraindications or data errors may be excluded. • Contraindication exclusions are allowed only as per current State specifications • Only the codes listed in specifications are counted as contraindications	☐	☐	☒	Calculation of the measure does not involve the exclusion of contraindications.
NUMERATOR					
7. Administrative Data: Counting Clinical Events	• Members are counted only once; double counting is prevented.	☒	☐	☐	Standard Codes specified under Section III D.4 PI #30; no double counting.
8. Medical Review Documentation Standards	Record abstraction tool required notation of the date that the abstraction was performed.	☐	☐	☒	Medical Record Review was not used for this measure.

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
9. Time Period	The number of members with an alcohol and other drug (AOD) claim who received any chemical dependency (CD) services, inpatient chemical dependency services, intermediate chemical dependency services, or ambulatory chemical dependency services during 1/1/2005 - 12/31/2005.	☒	☐	☐	Standard Codes specified under Section III D.4 PI #30; no double counting.
10. Data Quality	Properly identify enrollees	☒	☐	☐	Standard Codes specified under Section III D.4 PI #30 defines the specifications. Data quality is fairly accurate.
SAMPLING	IF ADMINISTRATIVE METHOD WAS USED, CHECK N/A FOR AUDIT ELEMENTS 11, 12 AND 13				
11. Unbiased Sample	• Systematic sampling method is utilized	☐	☐	☒	Sampling was not used for this measure.
12. Sample Size	• After exclusions, sample size is equal to (1) the appropriately reduced sample size, which used the current year's administrative rate or preceding year's reported rate, or (2) the total population	☐	☐	☒	Sampling was not used for this measure.
13. Proper Substitution Methodology in Medical Record Review (If no exclusions were taken, check NA)	• Only exclude members for whom medical record review revealed (1) contraindications that correspond to the codes listed in appropriate specifications or (2) data errors. • Substitutions are made for properly excluded records and the percentage of substituted records was documented	☐	☐	☒	Sampling was not used for this measure.

ADDITIONAL QUESTIONS	YES	NO
Were members excluded for contraindications found in the administrative data?	☐	☒
Were members excluded for contraindications found during the medical record review?	☐	☒
Were internally developed codes used?	☐	☒

What range defines the impact of data incompleteness for this measure? (Check one)	
0 - 5 percentage points	☒
>5 - 10 percentage points	☐
>10 - 20 percentage points	☐
>20 - 40 percentage points	☐
>40 percentage points	☐
Unable to determine	☐

What is the direction of the bias? Check one:	☐Over-Reporting ☒Under-Reporting

COMMENTS
The percentage of data that is incomplete is so insignificant that it does not cause any alarm

Upon what documentation is the above percentage based? (e.g., internal reports, studies, comparison to medical records, etc.)

COMMENTS:
Internal reports (claims processing III.D.1) and PBHC software assessment summary logs.

VALIDATION FINDING

FC = **FULLY COMPLIANT**
Measure was fully compliant with DMA specifications

SC = **SUBSTANTIALLY COMPLIANT**
Measure was substantially compliant with DMA specifications and had only minor deviations that did not significantly bias the reported rate

NV = **NOT VALID**
Measure deviated from DMA specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required

NA = **NOT APPLICABLE**
Measure was not reported because Piedmont did not have any Medicaid enrollees that qualified for the denominator

AUDIT DESIGNATION = **FC**

MPRO

PERFORMANCE MEASURMENT VALIDATION WORKSHEET

PERFORMANCE MEASURE:	Number of Consumers Moved from Institutional Care to Community Care

METHODOLOGY FOR CALCULATING MEASURE: (check one)	☒ Administrative ☐ Hybrid ☐ Medical Record

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes	☒	☐	☐	PBH annual report includes an attachment with unduplicated count of consumers eligible for C-waivers, the client identifier with discharge date, facility type and name of the facility.
DENOMINATOR					
1. Population	• Medicaid population appropriately segregated from commercial/Medicare • Population defined as effective Medicaid enrollment as of December 31, 2005	☒	☐	☐	Separate reports to be generated for (1) Medicaid (2) other. n-tiered model code incorporates the population specifications
2. Geographic Area	• Includes only Medicaid enrollees served in specified counties	☒	☐	☐	Receives claims for specific counties only
3. Age & Sex	• Members of all ages & sex	☒	☐	☐	csp_report_utilzation _PF_32 specifies all ages and sex

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
4. Enrollment Calculation	• Were members of plan as of 12/31/05	☒	☐	☐	csp_report_utilzation _PF_32 specifies enrollment for this measure
5. Data Quality	• Based on the IS process audit findings, are any of the data sources for this denominator inaccurate?	☒	☐	☐	Piedmont uses claims that have been processed and approved for payment to the Great Plains Accounting System in batches. Claims passing from the CI system to the Great Plains AP Module are verified by the CI report entitled, "CI Invoice by Great Plains Batch", when the data transfer is completed.
6. Proper Exclusion Methodology in Administrative Data (if no Exclusions were taken, check NA)	• Only members with contraindications or data errors may be excluded. • Contraindication exclusions are allowed only as per current State specifications • Only the codes listed in specifications are counted as contraindications	☐	☐	☒	Calculation of the measure does not involve the exclusion of contraindications.
NUMERATOR					
7. Administrative Data: Counting Clinical Events	Members are counted only once; double counting is prevented	☒	☐	☐	Standard Codes specified under Section III D.4 PI #32; no double counting
8. Medical Review Documenta-tion Standards	Record abstraction tool required notation of the date that the abstraction was performed	☐	☐	☒	Medical Record Review was not used for this measure.

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
9. Time Period	The number of members with an alcohol and other drug (AOD) claim who received any chemical dependency (CD) services, inpatient chemical dependency services, intermediate chemical dependency services, or ambulatory chemical dependency services during 1/1/2005 - 12/31/2005	☒	☐	☐	Standard Codes specified under Section III D.4 PI #32; no double counting
10. Data Quality	Properly identify enrollees	☒	☐	☐	Standard Codes specified under Section III D.4 PI #32 defines the specifications. Data quality fairly accurate
SAMPLING	IF ADMINISTRATIVE METHOD WAS USED, CHECK N/A FOR AUDIT ELEMENTS 11, 12 AND 13				
11. Unbiased Sample	• Systematic sampling method is utilized	☐	☐	☒	Sampling was not used for this measure.
12. Sample Size	• After exclusions, sample size is equal to (1) the appropriate reduced sample size, which used the current year's administrative rate pr preceding year's report rate, (2) the total population	☐	☐	☒	Sampling was not used for this measure.
13. Proper Substitution Methodology in Medical Record Review (If no exclusions were taken, check NA)	• Only exclude members for whom medical record review revealed (1) contraindications that correspond to the codes listed in appropriate specifications or (2) data errors. • Substitutions are made for properly excluded records and the percentage of substituted records was documented	☐	☐	☒	Sampling was not used for this measure.

ADDITIONAL QUESTIONS	YES	NO
Were members excluded for contraindications found in the administrative data?	☐	☒
Were members excluded for contraindications found during the medical record review?	☐	☒
Were internally developed codes used?	☐	☒

What range defines the impact of data incompleteness for this measure? (Check one)	
0 - 5 percentage points	☒
>5 - 10 percentage points	☐
>10 - 20 percentage points	☐
>20 - 40 percentage points	☐
>40 percentage points	☐
Unable to determine	☐

What is the direction of the bias? Check one:	☐Over-Reporting ☒Under-Reporting

COMMENTS
The percentage of data that is incomplete is so insignificant that it does not cause any alarm

Upon what documentation is the above percentage based? (e.g., internal reports, studies, comparison to medical records, etc.)

COMMENTS:
Internal reports (claims processing III.D.1) and PBHC software assessment summary logs.

VALIDATION FINDING

FC = **FULLY COMPLIANT**
Measure was fully compliant with DMA specifications

SC = **SUBSTANTIALLY COMPLIANT**
Measure was substantially compliant with DMA specifications and had only minor deviations that did not significantly bias the reported rate

NV = **NOT VALID**
Measure deviated from DMA specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required

NA = **NOT APPLICABLE**
Measure was not reported because Piedmont did not have any Medicaid enrollees that qualified for the denominator

AUDIT DESIGNATION = **FC**

PERFORMANCE MEASURMENT VALIDATION WORKSHEET
(Amended 10/26/06)

PERFORMANCE MEASURE:	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

METHODOLOGY FOR CALCULATING MEASURE: (check one)	☒ Administrative ☐ Hybrid ☐ Medical Record

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes	☒	☐	☐	csp_report_AOD_PF 33 1 specifies the programming code that includes this measure.
DENOMINATOR					
1. Population	• Medicaid population appropriately segregated from commercial/Medicare • Population defined as effective Medicaid enrollment as of December 31, 2005	☒	☐	☐	Separate reports to be generated for (1) utilization (2) other. N-tiered model code incorporates the population specifications.
2. Geographic Area	• Includes only Medicaid enrollees served in specified counties	☒	☐	☐	Receives claims for these counties only.
3. Age & Sex	• Members of ages 13 and over & both genders	☒	☐	☐	csp_report_AOD_PF 33 1 specifies the programming code that includes this measure.

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
4. Enrollment Calculation	• Were members of plan as of 12/31/05 and continuous enrollment for specific timeframes	☒	☐	☐	csp_report_utilzation _PF_29_30 specifies enrollment for this measure; however members need to be continuously enrolled 60 days prior through 44 days after the Index Episode Start Date. MPRO recommends that the denominator be corrected to meet this requirement. 10/26/06- Piedmont indicates that members can not be disenrolled.
5. Data Quality	• Based on the IS process audit findings, are any of the data sources for this denominator inaccurate?	☒	☐	☐	Piedmont uses claims that have been processed and approved for payment to the Great Plains Accounting System in batches. Claims passing from the CI system to the Great Plains AP Module are verified by the CI report entitled, “CI Invoice by Great Plains Batch”, when the data transfer is completed.
6. Proper Exclusion Methodology in Administrative Data (if no Exclusions were taken, check NA)	• Only members with contraindications or data errors may be excluded. • Contraindication exclusions are allowed only as per current State specifications • Only the codes listed in specifications are counted as contraindications	☒	☐	☐	All exclusions incorporated.

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
NUMERATOR					
7. Administrative Data: Counting Clinical Events	• Standard codes listed in specifications or properly map internally developed codes were used • Members are counted only once; double counting of New Member Assessment was prevented	☒	☐	☐	Standard Codes specified under Section III D.4 PI #33; no double counting.
8. Medical Review Documentation Standards	Record abstraction tool required notation	☐	☐	☒	Medical Record Review was not used for this measure.
9. Time Period	The number of members with initiation or treatment of AOD 1/1/2005 – 12/31/2005	☒	☐	☐	Standard Codes specified under Section III D.4 PI #33.
10. Data Quality	Properly identify enrollees	☒	☐	☐	Standard Codes specified under Section III D.4 PI #33 defines the specifications. Data quality fairly accurate.
SAMPLING	IF ADMINISTRATIVE METHOD WAS USED, CHECK N/A FOR AUDIT ELEMENTS 11, 12 AND 13				
11. Unbiased Sample	• Systematic sampling method is utilized	☐	☐	☒	Sampling was not used for this measure.
12. Sample Size	• After exclusions, sample size is equal to (1) the appropriately reduced sample size, which used the current year's administrative rate or preceding year's reported rate, or (2) the total population	☐	☐	☒	Sampling was not used for this measure.

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
13. Proper Substitution Methodology in Medical Record Review (If no exclusions were taken, check NA)	• Only exclude members for whom medical record review revealed (1) contraindications that correspond to the codes listed in appropriate specifications or (2) data errors. • Substitutions are made for properly excluded records and the percentage of substituted records was documented	☐	☐	☒	Sampling was not used for this measure.

ADDITIONAL QUESTIONS

QUESTIONS	YES	NO
Were members excluded for contraindications found in the administrative data?	☒	☐
Were members excluded for contraindications found during the medical record review?	☐	☒
Were internally developed codes used?	☒	☐

What range defines the impact of data incompleteness for this measure? (Check one)	
0 - 5 percentage points	☒
>5 - 10 percentage points	☐
>10 - 20 percentage points	☐
>20 - 40 percentage points	☐
>40 percentage points	☐
Unable to determine	☐
What is the direction of the bias? Check one:	☐Over-Reporting ☒Under-Reporting

COMMENTS
The percentage of data that is incomplete is so insignificant that it does not cause any alarm

Upon what documentation is the above percentage based? (e.g., internal reports, studies, comparison to medical records, etc.)

COMMENTS:
Programming logic does not incorporate continuous enrollment 60 days prior through 44 days after the Index Episode Start Date. This might cause some bias in the estimated rate because not all Medicaid enrollees would then be eligible for the measure.

10/26/06- Piedmont indicates that members can not be disenrolled. The members will always either have Medicaid or State funding. In the future, Piedmont should develop a process to differentiate between the two populations: Medicaid and State funded.

VALIDATION FINDING		
FC	=	**FULLY COMPLIANT** Measure was fully compliant with DMA specifications
SC	=	**SUBSTANTIALLY COMPLIANT** Measure was substantially compliant with DMA specifications and had only minor deviations that did not significantly bias the reported rate
NV	=	**NOT VALID** Measure deviated from DMA specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required
NA	=	**NOT APPLICABLE** Measure was not reported because Piedmont did not have any Medicaid enrollees that qualified for the denominator

AUDIT DESIGNATION	=	FC

MPRO

PERFORMANCE MEASURMENT VALIDATION WORKSHEET

PERFORMANCE MEASURE:	Utilization Management of the Provision of High Use Services

METHODOLOGY FOR CALCULATING MEASURE: (check one)	☒ Administrative ☐ Hybrid ☐ Medical Record

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes	☒	☐	☐	csp_report_high_use_srvc_PF_34-1 specifies the programming code that includes this measure.
DENOMINATOR					
1. Population	• Medicaid population appropriately segregated from commercial/Medicare • Population defined as effective Medicaid enrollment as of December 31, 2005	☒	☐	☐	Separate reports to be generated for (1) Medicaid (2) other. n-tiered model code incorporates the population specifications.
2. Geographic Area	• Includes only Medicaid enrollees served in specified counties	☒	☐	☐	Receives claims for these counties only.
3. Age & Sex	• Members of all ages & sex	☒	☐	☐	csp_report_high_use_srvc_PF_34-1 specifies all ages and sex.
4. Enrollment Calculation	• Were members of plan as of 12/31/05	☒	☐	☐	csp_report_high_use_srvc_PF_34-1 specifies enrollment for this measure.

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
5. Data Quality	• Based on the IS process audit findings, are any of the data sources for this denominator inaccurate?	☒	☐	☐	Piedmont uses claims that have been processed and approved for payment to the Great Plains Accounting System in batches. Claims passing from the CI system to the Great Plains AP Module are verified by the CI report entitled, "CI Invoice by Great Plains Batch", when the data transfer is completed.
6. Proper Exclusion Methodology in Administrative Data (if no Exclusions were taken, check NA)	• Only members with contraindications or data errors may be excluded. • Contraindication exclusions are allowed only as per current State specifications • Only the codes listed in specifications are counted as contraindications	☐	☐	☒	Calculation of the measure does not involve the exclusion of contraindications.
NUMERATOR					
7. Administrative Data: Counting Clinical Events	• Members are counted only once; double counting is prevented	☒	☐	☐	Standard Codes specified under Section III D.4 PI #34; no double counting.
8. Medical Review Documentation Standards	Record abstraction tool required notation of the date that the abstraction was performed	☐	☐	☒	Medical Record Review was not used for this measure.
9. Time Period	The number of members receiving personal care services, habilitation and respite services during 1/1/2005 - 12/31/2005	☒	☐	☐	Standard Codes specified under Section III D.4 PI #34; no double counting.

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
10. Data Quality	Properly identify enrollees	☒	☐	☐	Standard Codes specified under Section III D.4 PI #34 defines the specifications. Data quality fairly accurate
SAMPLING	IF ADMINISTRATIVE METHOD WAS USED, CHECK N/A FOR AUDIT ELEMENTS 11, 12 AND 13				
11. Unbiased Sample	• Systematic sampling method is utilized	☐	☐	☒	Sampling was not used for this measure.
12. Sample Size	• After exclusions, sample size is equal to (1) the appropriately reduced sample size, which used the current year's administrative rate or preceding year's reported rate, or (2) the total population	☐	☐	☒	Sampling was not used for this measure.
13. Proper Substitution Methodology in Medical Record Review (If no exclusions were taken, check NA)	• Only exclude members for whom medical record review revealed (1) contraindications that correspond to the codes listed in appropriate specifications or (2) data errors. • Substitutions are made for properly excluded records and the percentage of substituted records was documented	☐	☐	☒	Sampling was not used for this measure.

ADDITIONAL QUESTIONS	YES	NO
Were members excluded for contraindications found in the administrative data?	☐	☒
Were members excluded for contraindications found during the medical record review?	☐	☒
Were internally developed codes used?	☐	☒

What range defines the impact of data incompleteness for this measure? (Check one)	
0 - 5 percentage points	☒
>5 - 10 percentage points	☐
>10 - 20 percentage points	☐
>20 - 40 percentage points	☐
>40 percentage points	☐
Unable to determine	☐

What is the direction of the bias? Check one:	☐Over-Reporting ☒Under-Reporting

COMMENTS
The percentage of data that is incomplete is so insignificant that it does not cause any alarm

Upon what documentation is the above percentage based? (e.g., internal reports, studies, comparison to medical records, etc.)

COMMENTS:
Internal reports (claims processing III.D.1) and PBHC software assessment summary logs.

VALIDATION FINDING

FC = **FULLY COMPLIANT**
Measure was fully compliant with DMA specifications

SC = **SUBSTANTIALLY COMPLIANT**
Measure was substantially compliant with DMA specifications and had only minor deviations that did not significantly bias the reported rate

NV = **NOT VALID**
Measure deviated from DMA specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required

NA = **NOT APPLICABLE**
Measure was not reported because Piedmont did not have any Medicaid enrollees that qualified for the denominator

AUDIT DESIGNATION = **FC**

MPRO

PERFORMANCE MEASURMENT VALIDATION WORKSHEET

PERFORMANCE MEASURE:	Complaints / Grievances / Appeals

METHODOLOGY FOR CALCULATING MEASURE: (check one)	☒ Administrative ☐ Hybrid ☐ Medical Record

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes	☒	☐	☐	PBH Quarterly Complaints, Grievance and Appeals Report generates log for the received and resolved dates, complaint type, resolved outcome and number of days to resolve. The grievance report contains the category of grievance, level and finding; and the appeals report with a breakdown of appeals by MHSA and DD the level of review and the outcome.
DENOMINATOR					
1. Population	• Medicaid population appropriately segregated from commercial/Medicare • Population defined as effective Medicaid enrollment as of December 31, 2005	☒	☐	☐	Piedmont Binder Section III D.4 #67 DMA Quarterly Complaint Report contains logic for plans and programming.
2. Geographic Area	• Includes only Medicaid enrollees served in specified counties	☒	☐	☐	Receives claims for specific counties only.
3. Age & Sex	• Age specified • All genders selected	☐	☐	☒	Measure is not dependent on age or gender factors.

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
4. Enrollment Calculation	• Were members of plan as of 12/31/05	☒	☐	☐	Piedmont Binder Section III D.4 #67 DMA Quarterly Complaint Report contains logic for plans and programming.
5.Data Quality	• Based on the IS process audit findings, are any of the data sources for this denominator inaccurate?	☒	☐	☐	Piedmont Binder Section III D.4 #67 DMA Quarterly Complaint Report contains logic for plans and programming
6. Proper Exclusion Methodology in Administrative Data (if no Exclusions were taken, check NA)	• Exclusions were performed according to current specifications • Duplicate members identified with multiple date spans for eligibility are consolidated into one member record	☐	☐	☒	Calculation of the measure does not involve the exclusion of contraindications.
NUMERATOR					
7. Administrative Data: Counting Clinical Events	• Standard codes listed in specifications or properly map internally developed codes were used • Members are counted only once; double counting of New Member Assessment was prevented	☒	☐	☐	PBH Quarterly Complaints, Grievance and Appeals Report generates log for the received and resolved dates, complaint type, resolved outcome and number of days to resolve. The grievance report contains the category of grievance, level and finding; and the appeals report with a breakdown of appeals by MHSA and DD the level of review and the outcome.
8. Medical Review Documentation Standards	Record abstraction tool required notation of the date that the New Member Assessment was performed	☐	☐	☒	Medical Record Review was not used for this measure.

AUDIT ELEMENTS	AUDIT SPECIFICATIONS	MET	NOT MET	N/A	COMMENTS
9. Time Period	The number of members enrolled between 1/1/2005 and 12/31/2005.	☒	☐	☐	PBH claims processing check
10. Data Quality	• Properly identify enrollees • Based on the IS process audit findings, are any of the data sources used for this numerator inaccurate?	☒	☐	☐	PBH claims processing check on quality assures accuracy.
SAMPLING	IF ADMINISTRATIVE METHOD WAS USED, CHECK N/A FOR AUDIT ELEMENTS 11, 12 AND 13				
11. Unbiased Sample	• Systematic sampling method is utilized	☐	☐	☒	Sampling was not used for this measure.
12. Sample Size	• After exclusions, sample size is equal to (1) the appropriately reduced sample size, which used the current year's administrative rate or preceding year's reported rate, or (2) the total population	☐	☐	☒	Sampling was not used for this measure.
13. Proper Substitution Methodology in Medical Record Review (If no exclusions were taken, check NA)	• Only exclude members for whom medical record review revealed (1) contraindications that correspond to the codes listed in appropriate specifications or (2) data errors. • Substitutions are made for properly excluded records and the percentage of substituted records was documented	☐	☐	☒	Sampling was not used for this measure.

ADDITIONAL QUESTIONS	YES	NO
Were members excluded for contraindications found in the administrative data?	☐	☒
Were members excluded for contraindications found during the medical record review?	☐	☒
Were internally developed codes used?	☒	☐

What range defines the impact of data incompleteness for this measure? (Check one)	
0 - 5 percentage points	☒
>5 - 10 percentage points	☐
>10 - 20 percentage points	☐
>20 - 40 percentage points	☐
>40 percentage points	☐
Unable to determine	☐
What is the direction of the bias? Check one:	☐Over-Reporting ☒Under-Reporting

COMMENTS
The percentage of data that is incomplete is so insignificant that it does not cause any alarm

Upon what documentation is the above percentage based? (e.g., internal reports, studies, comparison to medical records, etc.)

COMMENTS:
PBH Quarterly Complaints Report generates log for the received and resolved dates, complaint type, resolved outcome and number of days to resolve. PBH also produces Performance Agreement Report For DMA that lists the number of enrollees within the quarter, the number of first level complaints, the number of complaints for second level review; the grievance report with the category of grievance, level and finding; and the appeals report with a breakdown of appeals by MHSA and DD.

VALIDATION FINDING

FC = **FULLY COMPLIANT**
Measure was fully compliant with DMA specifications

SC = **SUBSTANTIALLY COMPLIANT**
Measure was substantially compliant with DMA specifications and had only minor deviations that did not significantly bias the reported rate

NV = **NOT VALID**
Measure deviated from DMA specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required

NA = **NOT APPLICABLE**
Measure was not reported because Piedmont did not have any Medicaid enrollees that qualified for the denominator

AUDIT DESIGNATION = **FC**

2005
MEMORANDUM OF AGREEMENTS
BETWEEN
THE STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
AND
PIEDMONT BEHAVIORAL HEALTHCARE

Contract # 00011350

This Contract is hereby entered into by and between the North Carolina Department of Health and Human Services (the Department"), Division of Medical Assistance ("DMA") and Piedmont Area Mental Health, Developmental Disabilities and Substance Abuse Authority doing business as Piedmont Behavioral Healthcare, (herein referred to as "Piedmont" , "Contractor", or the "LME"), a political subdivision of the State of North Carolina, organized under North Carolina General Statute Chapter 122C, with its principal place of business at 245 Le Phillip Court in the city of Concord, County of Cabarrus, State of North Carolina. (referred to collectively as the "Parties"). Piedmont Behavioral Healthcare shall be a Prepaid Inpatient Health Plan for Medicaid recipients. The Contractor's federal tax identification number is 56-1071669.

1. **Contract Documents:** This Contract consists of the following documents:

(1) This master document
(2) The General Terms and Conditions (Attachment A)
(3) The Scope of Work (Attachment B)
(4) Background, Goals and Purpose (Attachment C)
(5) HIPAA Business Associate Addendum (Attachment D)
(6) Federal Certification Regarding Environmental Tobacco Smoke (Attachment E)
(7) Federal Certification Regarding Lobbying (Attachment F)
(8) Federal Certification Regarding Debarment (Attachment G)
(9) Federal Certification Regarding Drug-Free Workplace (Attachment H)
(10) Excerpts from NC General Statutes, Chapter 58 (Attachment I)
(11) Definition of Terms (Attachment J)
(12) Eligibility Groups (Attachment K)
(13) Schedule of Benefits (Attachment L)
(14) Scope of EPSDT Services (Attachment M)
(15) Statistical Reporting Measures (Attachment N)
(16) Requirements for Performance Improvement Projects (Attachment O)
(17) Grievance Procedures (Attachment P)
(18) Network Provider Qualifications (Attachment Q)
(19) Capitation Rates and Rate-Setting Methodology (Attachment R)
(20) Business Transactions (Attachment S)
(21) Provider Manuals and Bulletins (Attachment T)
(22) Access/Availability Standards (Attachment U)
(23) Guidelines for Stabilization Examination and Treatment for Emergency Medical Conditions and Women in Labor (Attachment V)
(24) Mixed Services Protocol (Attachment W)
(25) Financial Reporting Requirements (Attachment X)
(26) Penalties (Attachment Y)
(27) Advance Directives Brochure (Attachment Z)

These documents constitute the entire agreement between the Parties and supersede all prior oral or written statements or agreements.

2. **Precedence Among Contract Documents:** In the event of a conflict between or among the terms of the Contract Documents, the terms in the Contract Document with the highest relative precedence shall prevail. If there are multiple Contract Amendments, the most recent amendment shall have the highest precedence and the oldest amendment shall have the lowest precedence.

3. **Effective Period:** This contract shall be effective on or about April 1, 2005 and shall terminate in two years on or about March 31, 2007, with the option to extend, if mutually agreed upon, through a written amendment as provided for in the General Terms and Conditions as described in Attachment A.

4. **Contractor's Duties:** The Contractor shall provide the services as described in Attachment B, Scope of Work.

5. **Division's Duties:** DMA shall pay the Contractor in the manner and in the amounts specified in Attachment B, Scope of Work and all Appendices. The total amount paid by DMA to the Contractor under this contract shall not exceed $ _____.

6. **Conflict of Interest Policy:**

Contractor is a not a nonprofit agency; therefore, a conflict of interest policy is not required.

7. **Reporting Requirements:**

DMA has determined that this is a contract for purchase of goods and services, and therefore is exempt from the reporting requirements of N.C.G.S. § 143-6.1. Pamela Shipman
Chief Operating Officer
Piedmont Behavioral Healthcare
245 LePhillip Court
Concord, NC 28025

Telephone: 704-721-7000
Fax: 704-721-7010
Email: pshipman@pamh.com

8. **Payment Provisions:**
Payment shall be made as described in the Scope of Work,
Attachment B and Attachment R.

9. **Contract Administrators:** All notices permitted or required to be given by one Party to the other and all questions about the contract from one Party to the other shall be addressed and delivered to the other Party's Contract Administrator. The name, post office address, street address, telephone number, fax number, and email address of the Parties' respective initial Contract Administrators are set out below. Either Party may change the name, post office address, street address, telephone number, fax number, or email address of its Contract Administrator by giving timely written notice to the other Party.

DMA's Contract Administrator for Program Issues

IF DELIVERED BY US POSTAL SERVICE	IF DELIVERED BY ANY OTHER MEANS
Name Title – Carol Robertson Division of Medical Assistance Mail Service Center Number 2501 Raleigh, NC 27699- Telephone 919-855-4295 Fax 919-715-9025 Email Carol.Robertson@ncmail.net	Name Title Carol Robertson Division of Medical Assistance Street Address 1985 Umstead Drive, Kirby Building Raleigh, NC Zip 27603-2001

DMA's Contract Administrator for Contract Issues

IF DELIVERED BY US POSTAL SERVICE	IF DELIVERED BY ANY OTHER MEANS
Name Title Roger Odom, Chief of Contracting Division of Medical Assistance Mail Service Center Number 2501 Raleigh, NC 27699- Telephone - 919-855-4149 Fax 919-715-0896 Email Roger.Odom@ncmail.net	Name Title Roger Odom, Chief of Contracting Division of Medical Assistance Street Address 1985 Umstead Drive, Kirby Building Raleigh, NC Zip 27603-2001

For the Contractor:

IF DELIVERED BY US POSTAL SERVICE	IF DELIVERED BY ANY OTHER MEANS
Name Title Pamela Shipman, Chief Operating Officer Company Name Piedmont Behavioral Healthcare Post Office Address 245 LePhillip Court City State Zip Concord, NC 28025 Telephone 704-721-7000 Fax -704-721-7010 Email - pshipman@pamh.com	Name Title Pamela Shipman, Chief Operating Officer Company Name P iedmont Behavioral Healthcare Street Address 245 LePhillip Court City State Zip Concord, NC 28025

10. Outsourcing:

The Contractor certifies that it has identified to DMA all jobs related to the Contract that have been outsourced to other countries, if any. Contractor further agrees that it will not outsource any such jobs during the term of this Contract without providing notice to DMA.

11. Signature Warranty:

The undersigned represent and warrant that they are authorized to bind their principals to the terms of this agreement.

In Witness Whereof, the Contractor, DMA, and the Department have executed this contract in duplicate originals, with one original being retained by the Contractor and one being retained by DMA.

Piedmont Area Mental Health, Developmental Disabilities and Substance Abuse Authority

Signature — Date: 7/23/05

Daniel R. Coughlin — Area Director / CEO

Printed Name — Title

ATTEST

Signature — Date: 7-27-05

Dean Vick — PBH Board Director

Printed Name — Title

[CORPORATE SEAL]

North Carolina Department of Health and Human Services, Division of Medical Assistance

Signature — Date: 07/29/05

Mark Benton, Senior Deputy Director, Chief Operating Officer

North Carolina Department of Health and Human Services

Carmen Hooker Odom, Secretary — Date: 8/1/05

Relationships of the Parties

Independent Contractor: The Contractor is and shall be deemed to be an independent contractor in the performance of this contract and as such shall be wholly responsible for the work to be performed and for the supervision of its employees. The Contractor represents that it has, or shall secure at its own expense, all personnel required in performing the services under this agreement. Such employees shall not be employees of, or have any individual contractual relationship with, DMA.

Assignment: No assignment of the Contractor's obligations or the Contractor's right to receive payment hereunder shall be permitted. However, upon written request approved by the issuing purchasing authority, the State may:

(a) Forward the Contractor's payment check(s) directly to any person or entity designated by the Contractor, or

(b) Include any person or entity designated by Contractor as a joint payee on the Contractor's payment check(s).

In no event shall such approval and action obligate the State to anyone other than the Contractor and the Contractor shall remain responsible for fulfillment of all contract obligations.

Beneficiaries: Except as herein specifically provided otherwise, this contract shall inure to the benefit of and be binding upon the parties hereto and their respective successors. It is expressly understood and agreed that the enforcement of the terms and conditions of this contract, and all rights of action relating to such enforcement, shall be strictly reserved to DMA and the named Contractor. Nothing contained in this document shall give or allow any claim or right of action whatsoever by any other third person. It is the express intention of DMA and Contractor that any such person or entity, other than DMA or the Contractor, receiving services or benefits under this contract shall be deemed an incidental beneficiary only.

Indemnification

The Contractor agrees to indemnify and hold harmless DMA, the State of North Carolina, and any of their officers, agents and employees, from any claims of third parties arising out of any act or omission of the Contractor in connection with the performance of this contract to the extent permitted by law.

Default and Termination

Waiver of Default: Waiver by DMA of any default or breach in compliance with the terms of this contract by the Contractor shall not be deemed a waiver of any subsequent default or breach and shall not be construed to be modification of the terms of this contract unless stated to be such in writing, signed by an authorized representative of the Department and the Contractor and attached to the contract.

Availability of Funds: The parties to this contract agree and understand that the payment of the sums specified in this contract is dependent and contingent upon and subject to the appropriation, allocation, and availability of funds for this purpose to DMA.

Force Majeure: Neither party shall be deemed to be in default of its obligations hereunder if and so long as it is prevented from performing such obligations by any act of war, hostile foreign action, nuclear explosion, riot, strikes, civil insurrection, earthquake, hurricane, tornado, or other catastrophic natural event or act of God.

Survival of Promises: All promises, requirements, terms, conditions, provisions, representations, guarantees, and warranties contained herein shall survive the contract expiration or termination date unless specifically provided otherwise herein, or unless superseded by applicable Federal or State statutes of limitation.

Compliance with Applicable Laws

Compliance with Laws: The Contractor shall comply with all laws, ordinances, codes, rules, regulations, and licensing requirements that are applicable to the conduct of its business, including those of federal, state, and local agencies having jurisdiction and/or authority.

Confidentiality

Confidentiality: Any information, data, instruments, documents, studies or reports given to or prepared or assembled by the Contractor under this agreement shall be kept as confidential and not divulged or made available to any individual or organization without the prior written approval of DMA, except when information, data, instruments , documentation or reports are covered under the North Carolina Public Records Act N.C.G. S. 132. The Contractor acknowledges that in receiving, storing, processing or otherwise dealing with any confidential information it will safeguard and not further disclose the information except as otherwise provided in this contract.

Oversight

Access to Persons and Records: The State Auditor shall have access to persons and records as a result of all contracts or grants entered into by State agencies or political subdivisions in accordance with General Statute 147-64.7. Additionally, as the State funding authority, the Department of Health and Human Services shall have access to persons and records as a result of all contracts or grants entered into by State agencies or political subdivisions.

Record Retention: Records shall not be destroyed, purged or disposed of without the express written consent of DMA. The Department of Health and Human Services' basic records retention policy requires all records to be retained for a minimum of three years following completion or termination of the contract. If the contract is subject to Federal policy and regulations, record retention will normally be longer than three years since records must be retained for a period of three years following submission of the final Federal Financial Status Report, if applicable, or three years following the submission of a revised final Federal Financial Status Report. Also, if any litigation, claim, negotiation, audit, disallowance action, or other action involving this contract has been started before expiration of the three year retention period described above, the records must be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular three year period described above, whichever is later.

Miscellaneous

Choice of Law: The validity of this contract and any of its terms or provisions, as well as the rights and duties of the parties to this contract, are governed by the laws of North Carolina. The place of this contract and all transactions and agreements relating to it, and their situs and forum, shall be Wake County, North Carolina, where all matters, whether sounding in contract or tort, relating to the validity, construction, interpretation, and enforcement shall be determined.

Amendment: This contract may not be amended orally or by performance. Any amendment must be made in written form and executed by duly authorized representatives of DMA and the Contractor. The Purchase and Contract Divisions of the NC Department of Administration and the NC Department of Health and Human Services shall give prior approval to any amendment to a contract awarded through those offices.

Severability: In the event that a court of competent jurisdiction holds that a provision or requirement of this contract violates any applicable law, each such provision or requirement shall continue to be enforced to the extent it is not in violation of law or is not otherwise unenforceable and all other provisions and requirements of this contract shall remain in full force and effect.

Headings: The Section and Paragraph headings in these General Terms and Conditions are not material parts of the agreement and should not be used to construe the meaning thereof.

Time of the Essence: Time is of the essence in the performance of this contract.

Key Personnel: The Contractor shall notify DMA in writing of any changes in any of the key personnel assigned to the performance of this contract. The term "key personnel" includes any and all persons identified as such in the contract documents and any other persons subsequently identified as key personnel by the written agreement of the parties.

Care of Property: The Contractor agrees that it shall be responsible for the proper custody and care of any property furnished to it for use in connection with the performance of this contract and will reimburse DMA for loss of, or damage to, such property. At the termination of this contract, the Contractor shall contact DMA for instructions as to the disposition of such property and shall comply with these instructions.

Travel Expenses: The LME shall pay for all travel expenses incurred by the LME.

Sales/Use Tax Refunds: If eligible, the Contractor and all subcontractors shall: (a) ask the North Carolina Department of Revenue for a refund of all sales and use taxes paid by them in the performance of this contract, pursuant to N.C.G.S. 105-164.14; and (b) exclude all refundable sales and use taxes from all reportable expenditures before the expenses are entered in their reimbursement reports.

Attachment B

Scope of Work

1 Scope of Work

1.1 Definitions and Construction:

The terms used in this Contract shall have the definitions set forth in Attachment J, unless this Contract expressly provides otherwise. References to numbered Sections refer to the designated Sections contained in this Contract. Titles of Sections used herein are for reference only and shall not be deemed to be a part of this Contract.

1.2 Non-Discrimination:

The LME shall comply with all Federal and State laws which prohibit discrimination on the grounds of race, color, age, creed, sex, religion, national origin, or physical or mental handicap, including Title VI of the Civil Rights Act 42 U.S.C. 2000d and regulations issued pursuant thereto; the Americans with Disabilities Act, 42 U.S.C. 12101 et seq., and regulations issued pursuant thereto; Title IX of the

Education Amendments of 1972 and regulations issued pursuant thereto; the Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et. seq., and regulations issued pursuant thereto; the Rehabilitation Act of 1974, as amended, 29 U.S.C. 794, and regulations issued pursuant thereto; and furthermore shall not use any policy or procedures that discriminate on the basis of health status or need for health care services against individuals eligible to enroll.

In the provision of services under this agreement, the Contractor and its subcontractors shall comply with all applicable federal and state statues and regulations, and all amendments thereto, that are in effect when the agreement is signed, or that come into effect during the term of the agreement. This includes, but is not limited to Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations.

1.3 Financial Status and Viability:

The LME shall provide to DMA, copies of the LME's annual audit to verify its financial status, solvency and viability.

1.4 Departmental Monitoring Team:

DMA will monitor the Contractor throughout the term of the contract. DMA will maintain an Intra-Departmental Monitoring Team to provide monitoring and project oversight throughout the course of this Contract. This Monitoring Team shall meet at least four times a year, and more often if needed. The Monitoring Team shall conduct an Annual on-site review. The Monitoring Team shall review Performance Indicators, reports and data, and timeliness of submission of reports. The Monitoring Team may require the LME to develop an Action Plan when deficiencies are severe or recurrent or if the LME fails to address noted deficiencies in a timely manner. The Action Plan shall be sent to DMA and monitored until the problem is resolved.

DMA will have the right to impose penalties and sanctions, arrange for Temporary Management, as specified under Section 14, or immediately terminate this Contract under conditions specified in 13.4, independent of the actions of the Intra-Departmental Monitoring Team.

DMA will lead the Departmental Monitoring Team and have sole authority over Medicaid services covered in this Contract. The membership of the Intra-Departmental Monitoring Team shall include representation from the following, at minimum:

DMA:
1. Finance Management
2. Behavioral Health, Clinical Policies and Programs
3. Managed Care
4. Budget Management

DMH/DD/SA:
1. Best Practice
2. Budget
3. LME Team
4. Regulatory

LME:
1. Management
2. Finance
3. Operations (Access, Network, Waiver Implementation)
4. Quality
5. Others to be identified if needed

The Department:
1. Office of the Controller
2. Office of Budget and Analysis

1.6 Scope of Monitoring Activities:

The Monitoring Team shall conduct routine monitoring of the following in order to identify problems, deficiencies, and barriers to desired performance, to develop improvement strategies, to determine the need for Corrective Action Plans, and monitor any Corrective Action Plans in place:

a. Statistical Reporting Measures: Data and measurements of quality of care, service, and performance improvement projects. Attachment N.
b. Grievances: Attachment P.
c. Network Provider Qualifications: Attachment Q.
d. Access/Availability Standards : Attachment U
e. Financial Reporting Requirements: Attachment X

1.7 Monitoring Process:

The Monitoring Team shall use a Continuous Quality Improvement approach to review the performance of the LME. The Team shall routinely review, analyze, and interpret data. The purpose is to discover system performance problems, identify performance barriers, and develop improvement strategies, including Corrective Action Plans. The Team shall monitor improvement strategies and Corrective Action Plans to ensure that identified problems are improved. This process shall document both the challenges and successes of this LME Demonstration Project.

a. A written agenda shall identify the issues to be addressed at each team meeting. Those issues shall include, but not be limited to:

    1. Performance
    2. State concerns and questions
    3. the LME's challenges, barriers, and need for assistance
    4. Project successes
    5. Need for changes, improvements, or Corrective Action Plans.
    6. Progress on identified problems or Corrective Action Plans.
    7. Monitor expenditures and cost of the Contracted activites.

b. Minutes shall be kept of all meetings.

1.8 Annual Monitoring Review:

DMA and DMH shall conduct an Annual Monitoring Review on-site at the LME. The Monitoring Review shall include a review of:

a. The LME's compliance with the requirements of this Contract;
b. The LME's compliance with State and Federal Medicaid requirements;
c. The LME's compliance with N.C.G.S. 122C-112.1;
d. Implementation of the LME's Local Business Plan.

To the extent possible, the review shall not duplicate areas assessed by the National Accrediting Body (once LME accreditation has been achieved).

1.9 Conflict of Interest - 42 C.F.R. 438.58:

No officer, employee or agent of any State or Federal agency that exercises any functions or responsibilities in the review or approval of this Contract or its performance shall acquire any personal interest, direct or indirect, in this Contract or in any subcontract entered into by the LME. No official or employee of the LME shall acquire any personal interest, direct or indirect, in any network provider.

The LME hereby certifies that:

- no officer, employee or agent of the LME;
- no subcontractor or supplier of the LME; and
- no person with an ownership or control interest in the LME;

is employed by the State of North Carolina, the federal government, or the Fiscal Agent in any position that exercises any authority or control over the LME, this Contract, or its performance.

The LME further certifies that any State employee serving on the LME's Board of Directors shall recuse himself from participating in any manner in any discussion or action by the Board concerning the State agency that employs the Board member.

1.11 Risk Reserve:

The LME shall establish and maintain a restricted risk reserve account with a federally guaranteed financial institution licensed to do business in the state of NC in accordance with Section 1903(m)(1) of the Social Security Act (amended by Section 4706 of the Balanced Budget Act of 1997). The LME shall on a monthly basis deposit into the risk reserve account an amount equal to two percent (2%) of the capitation payments received from DMA until a maximum total of fifteen percent (15)% of the annualized total current DMA contract amount is achieved. Once the risk reserve account balance equals 15%, contributions shall terminate. Withdrawals, including interest, are prohibited until the risk reserve account equals or exceeds 15% of the annualized total current contract amount. Contributions to the risk reserve account shall resume if the risk reserve balance falls below 15%. This provision shall remain in effect until the contract with DMA and the LME terminates. Upon the approval of the Director of the Division of Medical Assistance, the risk reserve may be used by the LME to meet outstanding obligations incurred under this Contract. In the event of the LME's insolvency, the LME's inability to issue final payments (upon termination of the contract), and the LME's cost overruns, determined at the end of the fiscal year. Upon the approval of the Director of the Division of Medical Assistance and the Director of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, the risk reserve may be used for start–up and system enhancements in accordance with the requirements for the expenditure of funds under section 1915(b) of the Social Security Act. If the contract terminates, expires or does not continue, the risk reserve balance shall become the property of the LME, upon receipt of proof by DMA and DMH/DD/SAS that all outstanding obligations incurred under this contract have been met.

1.12 Financial Reporting and Viability Measures:

The Contractor shall maintain a fund balance in accordance with APSM 75-1 Rule 1015 Fund Balance Computation for Area Programs and the Memorandum of February 8, 2000 from Joyce Johnson, NCDHHS Controller, regarding required fund balance parameters for Area Programs and reporting for the Fiscal Monitoring Report.

a. General Requirements:

1. All funds received by the LME pursuant to this Contract shall be accounted for by tracking Title XIX Medicaid expenditures separately from services provided using other funding, as specified in the Financial Reporting Requirements, Attachment X.

2. DMA shall monitor the Services Expense Ratio and the Administrative Cost Percentage. These expenses shall be analyzed as part of DMA's due diligence in financial statement monitoring and in order to enable DMA to report financial data to CMS.

1.14 Disputes:

Disputes that arise out of this Contract between the LME and DMA shall be resolved by DMA's Contract Administrators. If the LME is not satisfied with the Contract Administrator's decision, the LME may invoke any administrative or legal remedy available to it under State and federal law. Pending appeal, the LME shall proceed diligently with the performance of this Contract, unless the LME obtains a stay from an administrative law judge or court of competent jurisdiction.

1.15 Disclosure of Information on Ownership and Control:

The LME shall disclose to DMA information on ownership and control of the LME prior to the beginning of the Contract term, as set forth in Title 42 C.F.R. 455.104.

1.16 Disclosure of Information on Business Transactions:

LMEs which are not Federally qualified HMOs shall disclose to DMA information on certain types of transactions they have with a "party in interest" as defined in the Public Health Service Act (see Sections 1903(m)(2)(A)(viii) and 1903(m)(4) of the Act.). This requirement is detailed further in Attachment S.

1.17 Excluded Providers:

The LME shall not employ or contract with providers excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act. DMA shall not reimburse the LME for any services rendered by providers excluded as identified above.

SECTION 2 - CONTRACT PROCUREMENT AND MAINTENANCE

2.1 Procurement Process:

Single Prepaid Inpatient Health Plan PIHP:

The North Carolina General Assembly, in Session Law 2001-437, designated the local mental health authorities as the "locus of coordination" for the provision of all publicly funded MH/DD/SA services. The law redirects the mission of the local authorities from providers of MH/DD/SA services to managers of services and requires that each local authority develop a business plan for the management, delivery, and oversight of public MH/DD/SA services. Piedmont Behavioral Healthcare is a local mental health authority, a multi-county political subdivision of the State of North Carolina established and operating in accordance with NC General Statute 122C (N.C.G.S. 122C-116), known as an "area authority". Given the newly defined role of the area authorities to manage all publicly funded MH/DD/SA services, it is logical and efficient to establish Piedmont Behavioral Healthcare as the single Prepaid Inpatient Health Plan through which all mental health, substance abuse and developmental disability services shall be authorized for Medicaid recipients in the five-county catchment area. This shall facilitate comprehensive and integrated service delivery as referenced in 45 C.F.R. 74.4. The counties included in the Piedmont catchment area are:

Cabarrus
Davidson
Rowan
Stanly
Union

Piedmont has submitted information in the form of A Local Business Plan, prescribed by the North Carolina Department of Health and Human Services, that fully describes its ability to meet the specifications of the Contract. Piedmont has provided detailed information on the provider network that shall be developed under this prepaid health plan.

SECTION 3 - ELIGIBILITY

3.1 Persons Eligible for Enrollment:

To be eligible to enroll in the PIHP established pursuant to this Contract, a person shall be a recipient in the North Carolina Medical Assistance (Medicaid) Program in one of the aid categories listed below, and with county of residence for Medicaid eligibility purposes of Cabarrus, Davidson, Rowan, Stanly, or Union Counties.

a. Individuals covered under Section 1931 of the Social Security Act (1931 Group, TANF/AFDC)
b. Optional Categorically and Medically Needy Families and Children not in Medicaid deductible status (MAF)
c. Blind and Disabled Children and Related Populations (SSI)
d. Blind and Disabled Adults and Related Populations (SSI, Medicare)
e. Aged and Related Populations (SSI, Medicare)
f. Medicaid for the Aged (MAA)
g. Medicaid for Pregnant Women (MPW)
h. Medicaid for Infants and Children (MIC)
i. Adult Care Home Residents (SAD, SAA)
j. Foster Care Children
k. Participants in Community Alternatives Programs (CAP/DA, CAP-MR/DD, CAP/AIDS)
l. Medicaid recipients living in ICFs-MR
m. Children, beginning the first day of the month following the third birthday (except for CAP-MR/DD)

3.2 Persons Ineligible for Enrollment:

The following categories of people receiving Medicaid are not eligible to enroll in the PIHP:

a. Medicare Qualified Beneficiaries (MQB)
b. Non-qualified Aliens or Qualified Aliens during the five (5) year ban
c. Medically Needy in deductible status
d. Children within the age of 0-36 months, except for CAP-MR/DD participants
e. Recipients with Presumptive Eligibility
f. Refugee Assistance

SECTION 4 - ENROLLMENT AND DISENROLLMENT

4.1 Plan Enrollment:

Individuals receiving Medicaid shall be enrolled in the LME based on county of residence of Medicaid eligibility. All individuals receiving Medicaid with county of Medicaid eligibility of Cabarrus, Davidson, Rowan, Stanly and Union shall be subject to enrollment except those persons listed in Section 3.2, above.

The LME shall not discriminate against individuals on the basis of race, color, or national origin and shall not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin. Furthermore, the LME shall not discriminate on the basis of health status or the need for health care services.

4.2 Change of Household Composition:

The LME shall report to the County DSS any known change in the household composition affecting eligibility for Medicaid of Enrollee, including changes in family size, marital status or residence, within five (5) days of such information being known to the LME.

4.3 Children:

Eligibility for services for children shall begin the first day of the month following the third birthday, except for children participating in the Piedmont home and community based services waiver, the "Innovations" program. Eligibility for participation in the Innovations waiver shall begin at birth.

4.4 Effective Date of Enrollment/Disenrollment:

An enrollment period shall always begin on the first day of a calendar month and shall end on the last day of a calendar month, with the exception of newborns.

4.5 Retroactive Disability Determination:

When a retroactive disability determination is made for a Recipient who is enrolled in a PIHP, the change in payment category shall occur at the time of the change in the Recipient's aid program category within DMA's Eligibility Information System (EIS). Changes in recipient aid program categories are not generally retroactive for the Blind and Disabled.

4.6 Automatic Disenrollment:

An enrollee shall be automatically disenrolled from the LME if the Recipient:

a. Changes county of residence for Medicaid eligibility purposes to a county other than Cabarrus, Stanly, Rowan, Union or Davidson;
b. Is deceased;
c. Is admitted to a correctional facility for more than thirty (30) days;
d. No longer qualifies for Medicaid or becomes a Recipient ineligible for enrollment as defined in Section 3.2;
e. Is admitted to an IMD (Institution for Mental Disease).

4.7 Involuntary Disenrollment:

Involuntary disenrollment does not apply because Piedmont is a public agency and does not discharge consumers who need services and meet medical necessity requirements.

4.8 Disenrollment Date:

When an enrollee changes county of residence for Medicaid eligibility purposes to a county other than Cabarrus, Davidson, Rowan, Stanley or Union, the individual will continue to be enrolled in the LME until the disenrollment is processed by the Eligibility Information System (EIS). DMA shall continue to pay the LME a capitated PMPM payment for the enrollee until disenrollment is effective in the EIS. Disenrollment due to change of residence is always effective at midnight on the last day of the month. The LME shall be responsible for all medically necessary services to the enrollee until EIS disenrollment occurs.

SECTION 5 – MARKETING

Because enrollment in Piedmont LME is mandatory, Piedmont LME shall not be required to comply with CMS's marketing regulations.

SECTION 6 - DUTIES AND RESPONSIBILITIES OF THE CONTRACTOR

6.1 Duties of the LME

The LME shall:

a. provide all statistical reports identified in Attachment N and update those reports as required under this Contract and Attachment N;
b. provide Financial Reports as delineated in Attachment X;
c. upon request by DMA, make available both financial and non-financial data involving Medicaid recipients enrolled with the LME.
d. provide access to all files, data, and reports to other entities and organizations under contract to DMA for the purpose of conducting audits, studies, data validation and similar activities. Any disputes between the other DMA contract entities and the LME shall be resolved by DMA; except where those disputes are covered under NCGS 122C-151.4.
e. have adequate professional staff in place to perform all functions of this Contract;
f. have sufficient internal controls and systems in place to account for Contract-related and non-Contract-related revenues and expenses separately. Internal controls shall also be in place to prevent and detect fraud. These controls shall be included in the LME's Corporate Compliance Plan;
g. submit reports, as outlined in this Contract as developed and amended by DMA;
h. submit ad-hoc reports requested by DMA at the times agreed upon by DMA and the LME;
i. submit financial reports as delineated in Attachment X, in accordance with Generally Accepted Accounting Principals (GAAP);
j. and upon request by DMA, provide clarification on financial reports/accounting issues that arise.
k. as a result of analysis by DMA.

The LME's annual financial reports shall be audited in accordance with Generally Accepted Auditing Standards (GAAS) by an independent Certified Public Accountant at the LME's expense. If applicable, financial reports shall be audited in accordance with the Office of Management and Budget (OMB) Circular A-133, and a the cost allocation plan shall be audited in accordance with OMB Circular A-122. Piedmont shall provide copies of the annual audit to DMA.

The annual financial audit and cost allocation plans are subject to annual independent verification and audit by a firm of DMA's choosing. Reimbursement for such audits shall be the responsibility of DMA.

6.2 Covered Services:

The LME shall provide to Enrollees covered under this Contract, through arrangements with others, all of the Covered Services identified in Attachment L. These services shall be provided in the manner set forth in this contract. The amount, duration, and scope of these services shall be no less than the amount, duration, and scope of the same services furnished to Enrollees under fee-for-service Medicaid. The amount, duration, and scope of services must reasonably be expected to achieve the purpose for which the services are furnished. Covered services shall be Medically Necessary and shall be provided by a qualified provider. The LME shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness or condition. LME Covered Services are defined in the State's Medicaid Provider Manuals, Bulletins and Clinical Coverage Policies, which are incorporated herein by reference. The LME shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions and shall consult with requesting providers when appropriate. The LME may establish utilization management requirements that are different from State Plan requirements. The LME may place appropriate limits on a service on the basis of criteria such as medical necessity and for utilization control, provided that the services furnished can reasonably be expected to achieve their purpose.

The LME and its subcontractors shall have in place and follow written policies and procedures for processing requests for initial and continuing authorizations of services.

Attachment W specifies responsibility for payment of mixed services between general medical providers and the LME.

6.3 Emergency Medical Services:

In accordance with Section1932(b)(2) of the Social Security Act, as amended by the Balanced Budget Act (BBA) of 1997, the LME shall provide coverage for Emergency Behavioral Health Services consistent with the prudent layperson standard, as defined in Attachment J. Such services shall be provided at anytime without regard to prior authorization and without regard to the emergency care provider's contractual relationship with the LME. The LME shall also comply with guidelines relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care provided to a Medicaid enrollee who is determined to be stable by a medical screening examination, as required under the Examination and Treatment for Emergency Medical Conditions and Women in Labor Act – EMTALA. (Section 1867 of the Social Security Act). (See Attachment V). The LME is responsible for educating Enrollees on the availability, location, and appropriate use of Emergency Services. The LME shall not deny payment for treatment obtained when an enrollee had an emergency medical condition, including but not limited to, cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 C.F.R. 438.114(a) of the definition of emergency medical condition. The LME shall not deny payment or treatment obtained when a representative of the LME instructs the enrollee to seek Emergency Services. Refer to Attachment V Emergency Medical Services and Attachment W, Mixed Services Protocol.

6.4 Accessibility of Services:

The LME shall establish and maintain appropriate provider networks that are sufficient to provide adequate access to all services covered under the contract for the enrolled Medicaid population. These provider networks shall offer an appropriate range of services and access. This network of appropriate providers shall be supported by written agreements. The network shall have a sufficient number, mix, and geographic distribution of providers of services to assure DMA that medically necessary Covered Services for the LME's Members are delivered in a timely and appropriate manner according to the Access Standards specified within this contract and Attachment U. Provider selection procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. If particular specialty services are Medically Necessary but are not accessible within the LME's network, the LME shall arrange for these services to be provided to its enrollees. The LME shall adequately and timely cover these services out of network for the enrollee for as long as the LME is unable to provide them in network. The LME shall ensure that the cost to the Enrollee is not greater than it would be if the services were furnished within the network. The LME shall ensure that no incentive is provided to providers, monetary or otherwise, for withholding medically necessary services. The LME shall provide for a second opinion from a qualified health care professional within the network, or arrange for the ability of the Enrollee to obtain one outside the network, at no cost to the Enrollee.

1. The LME shall establish policies and procedures to monitor the adequacy, accessibility, and availability of its provider network to meet the needs of Enrollees, according to the standards approved by DMA and as defined herein in 6.4, including the provision of care to Enrollees with limited proficiency in English.
2. The LME shall include in its agreements with participating providers a provision by which the participating providers agree to participate in the LME's utilization management, care management, quality management, qualification/accreditation and credentialing process.

3. The LME shall conduct an analysis of its provider network to demonstrate an appropriate number, mix, and geographic distribution of providers, including an analysis of geographic access of its memberships to practitioners and facilities. The LME shall consider:
   a. Anticipated membership numbers, characteristics, and needs, including cultural and language issues
   b. Anticipated utilization of services
   c. Number and types of providers required to provide the contracted services, including training, experience, and specialization
   d. Network providers who are not accepting new referrals
   e. The geographic location of providers and Recipients, considering distance, travel time, means of transportation and physical access for Recipients with disabilities.
4. The analysis referenced in item 3 above may be required at the initiation of the contract and annually thereafter. The LME may be required to conduct additional studies of access when there is a substantial change in its operations or in enrollees.
5. Whenever network gaps are noted, the LME shall submit to the state a network development plan or strategy as well as reports on the implementation of the plan or strategy.
6. The LME shall require that Network Providers offer hours of operation that are no less than the hours of operation offered to Medicaid fee-for-service, if the provider serves only Medicaid Enrollees.
7. The LME shall implement timely access monitoring as follows:
   a. Establish mechanisms to ensure that network providers comply with the timely access requirements as specified in 6.5 and 6.6;
   b. Monitor regularly to determine compliance;
   c. Take corrective action if there is a failure to comply.

The LME shall submit documentation assuring adequate capacity and services as specified by DMA and no less frequently than: at the time it enters into a contract with DMA; and at any time there has been a significant change in the LME's operations that would affect adequate capacity and services, including changes in services, benefits, geographic service areas or payments, or enrollment of a new population in the LME.

The LME shall provide toll-free telephone access and emergency referral, either directly or through its network providers, to Enrollees twenty-four (24) hours per day, seven (7) days per week. The LME shall maintain a record of encounters on the telephone access line, including the date of call, type of call, and disposition. The LME shall be responsible for educating Enrollees on access and emergency referral procedures.

DMA shall have the right to review periodically the adequacy of service locations, the hours of operation, and the availability and appropriateness of telephone response. DMA may require the LME to take corrective action to improve enrollee access to services. DMA may terminate this Contract if the LME fails to take corrective actions as specified in Section 13, Default and Termination.

6.5 Appointment Availability (Access Standards):

The LME shall ensure that appropriate services are available as follows:

a. Emergency – within one hour; immediate for life threatening emergencies
b. Urgent care - within forty-eight (48) hours
c. Routine need - within seven (7) days
d. Telephone access and emergency referral – twenty four (24) hours a day and return call to Enrollee within one (1) hour

The LME shall monitor these standards and address problems through the Continuous Quality Improvement process.

6.6 Appointment Wait Time (Access Standards):

The LME shall agree to provide services within the following wait times:

a. Scheduled appointment - within one (1) hour;
b. Walk-in - within two (2) hours or schedule for subsequent appointment;
c. Emergency- within one hour; life threatening emergencies shall be managed immediately.

6.7 Customer Services:

The LME shall have a Customer Service function that is responsive to Enrollees, and their families. Responsiveness of the Customer Service function shall be monitored and measured through the activities described in Section 7.0, Quality Assurance and Performance Improvement. Such activities shall include but not be limited to patient satisfaction surveys (Section 7.1); performance improvement projects (Section 7.1); external quality reviews (Section 7.2); and grievance and appeals data. The Customer Service Function shall:

a. Respond to inquiries and assist recipients, family members and stakeholders in a manner that resolves their inquiry, including the ability to respond to those with limited English proficiency;
b. Connect Enrollees, family members, or stakeholders to crisis services when indicated;
c. Process referrals, including request for services;
d. Provide information on where and how to access behavioral health services;
e. Log all complaints and arrange for appropriate follow-up, including notification of the Enrollee of the resolution. The LME shall train staff to know how to distinguish among a complaint, Third Party Insurance issue, Recipient Appeals and Grievances and how to triage these to the appropriate party;
f. Answer phones and respond to inquiries from 8:30 a.m. until 5:00 p.m. weekdays;
g. Process referrals 24 hours per day, 7 days per week.

6.8 Choice of Health Professional:

To the extent reasonably possible and appropriate, the LME shall offer freedom of choice to Enrollees in selecting a provider from within the LME's qualified provider network. The LME shall ensure a choice of at least two providers for each level of care, except specialties specifically approved by DMA in writing. Requests for exceptions may be based on such factors as medical necessity and demand. For example, exemptions may be granted if the demand for services, particularly facility based services or niche services, does not support two providers.

An Enrollee who has received prior authorization from the LME for referral to a Network Provider or for inpatient care shall be allowed to choose from among all the available Network Providers and hospitals within the LME, to the extent reasonable and appropriate.

The LME shall implement procedures to coordinate the services it furnishes Enrollees with the services Enrollees receive from any other MCO, Prepaid Inpatient Health Plan (PIHP) or Prepaid Ambulatory Health Plan (PAHP). The LME shall implement procedures to coordinate with other MCOs, PIHPs or PAHPs serving the Enrollee so that those activities need not be duplicated.

6.9 Facilities and Resources:

The LME shall provide directly or by contract the following:

a. Sufficient numbers of experienced and qualified utilization and Care Management staff to meet the terms of this Contract. Utilization and Care Managers **shall** be at **minimum** Master's level Behavioral Health professionals **licensed by the State of North Carolina** with a minimum of two years post Master's experience in a clinical setting. Authorization

for developmental disabilities services shall be completed by a Qualified Professional in the area of Developmental Disabilities as specified in 42 CFR 483.430 (a) and N.C. Gen. Stat. §122C3.

b. A designated emergency service facility providing care twenty four (24) hours per day, seven (7) days per week
c. Facilities at all service locations, which meet the applicable Federal, State, and local requirements pertaining to health care facilities and laboratories; all laboratory testing sites providing services under the Contract shall have either a Clinical Laboratory (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number
d. Telecommunications system sufficient to meet the needs of the Enrollees with a 24 hours per day, seven days per week access to an intake line with clinical back-up by a licensed Master's level clinician
e. Sufficient support staff
f. A physician, **licensed in the State of North Carolina,** to serve as Medical Director to oversee and be responsible for the proper authorization and review of covered Services to Enrollees. The Medical Director shall ensure that staff conducting reviews operate within the scope of their areas of clinical expertise
g. The utilization, care management, and medical team shall include members with expertise that reflects the prevalent disorders of the populations served
h. A Quality Assurance Director. The Quality Assurance Director shall have at minimum: a Bachelor's Degree in a Human Services Field and five years of post Bachelor's Degree experience; or a Master's Degree in a human services field and two years of post Master's Degree experience.
i. A data processing person qualified to provide necessary and timely reports and encounter data to DMA

6.10 Information for New Enrollees:

At the time of approval of the Medicaid eligibility application, DMA shall send new Eligibles (Potential Enrollees) written information explaining how to access services from the LME. Information on the services and benefits provided by the LME and LME contact information shall be included.

6.11 Enrollee Education:

The LME shall provide each new Enrollee that requests services, within fourteen (14) days of the request for services, written information on the Medicaid waiver program. Written information shall be available in Spanish and in any additional languages which are spoken by a substantial number of persons served by the LME. "Substantial number" is defined as 5% of the LME's enrollees or 1,000 enrollees, whichever is less. All new Enrollee material shall be approved by DMA prior to its release, and shall include at least the following information, as specified in 42 C.F.R 438.10 (f)(6) and 42 C.F.R. 438.10 (g):

a. A list of all Network Providers;
b. The procedures for obtaining benefits, including authorizations, and selecting a Network Provider;
c. Procedures for changing Network Providers
d. Any restrictions on freedom of choice of Network Providers;
e. Names, locations, telephone numbers and non-English languages spoken by current contracted providers, including identification of providers that are not accepting new patients;
f. Benefits and services provided and any limitations or exclusions applicable to Covered services in sufficient detail to ensure that Enrollees understand the benefits to which they are entitled;
g. Procedures for notifying Enrollees affected by the termination or modification of any benefits, services, service delivery, or provider location;
h. Enrollee rights, protections and responsibilities, including the right to voluntarily change Network Providers within the Network;

i. Provisions for after-hour and emergency care, including 911 telephone system or local equivalent;
j. The extent to which and how after-hours and emergency coverage are provided, including:
k. What constitutes an Emergency Behavioral Health Condition, Emergency Services, and Post Stabilization Services (Attachment V of this document);
    i. The process and procedures for obtaining Emergency Services, including the use of 911 telephone services or the equivalent;
    ii. The locations of any Emergency settings and other locations at which providers and hospitals furnish Emergency Services and Post Stabilization services covered under the contract and that, subject to the provisions of this contract, the Enrollee has a right to use any hospital or other setting for Emergency Care;
    iii. Post Stabilization Care services.
l. Policy on referrals for Specialty Care:
    i. Cost sharing if any;
    ii. How and where to access any benefits that are available under the State plan but are not covered by Medicaid.
m. Grievance, Appeal, and Fair Hearing procedures and timeframes, as specified by the State:
    i. For State Fair Hearing:
        1. The right to a Fair Hearing;
        2. The method for obtaining a Fair Hearing; and
        3. The rules that govern representation at Fair Hearings;
    ii. The right to file Grievances and Appeals;
    iii. The requirements and timeframes for filing a grievance or Appeal;
    iv. The availability of assistance in the filing process;
    v. The toll-free numbers that the Enrollee can use to file a Grievance or an Appeal by phone;
    vi. The fact that, when requested by the enrollee:
        1. Benefits shall continue if the Enrollee files a Grievance or an Appeal or a request for a State Fair Hearing within the timeframes specified for filing;
        2. The Enrollee may be required to pay the cost of services furnished while the Appeal is pending, if the final decision is adverse to the Enrollee.
n. The right to formulate Advance Directives;
o. Procedures for obtaining out of area coverage or services;
p. Policies regarding the treatment of minors;
q. Any limitations that may apply to services obtained from Out-of Network Providers, including disclosure of the responsibility of the Enrollee to pay for unauthorized behavioral health care services obtained from Out-of-Network Providers, and the procedures for obtaining authorization for such services;
r. Rights, procedures and timeframes for voicing or filing Grievances and Appeals or recommending changes in policies and services;
s. Rights, procedures and timeframes for appealing adverse determinations affecting coverage, benefits or enrollment, including the right to appeal directly to DMA;
t. Information about medically necessary transportation services provided by the Department of Social Services in each county;
u. Updates of program changes;
v. Accommodations for non-English speakers as specified in 42 C.F.R. 438.10 (c) (5);
w. Enrollee rights and responsibilities as set forth in 42 C.F.R. 438.100 and sections referenced therein, as specified in 6.16;
x. The identity, locations, qualifications and availability of providers that are enrolled in the LME Provider Network;
y. Information on Covered Items and Services;
z. Written information shall be made available in the prevalent non-English languages in a particular service area;
aa. Availability of oral interpretation service for any language and how to access the service;
bb. Availability of interpretation of written information in prevalent languages and how to access those services;

cc. The LME shall provide information on the structure and operation of the agency and any physician incentive plans, upon the request of the enrollee.

All written material shall use an easily understood language and format, and be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. All enrollees shall be informed that information is available in alternative formats and how to access those formats.

All written materials created after the effective date of this Agreement shall be consistent with the North Carolina readability requirements as set forth in N.C.G.S. 58-38-1, N.C.G.S. 58-38-5, N.C.G.S. 58-38-10(d), N.C.G.S. 58-38-15, N.C.G.S. 58-38-20 and N.C.G.S. 58-38-25. All material to be printed for recipients shall be approved in writing by DMA prior to printing and dissemination. The LME shall make oral interpretation services available free of charge to each enrollee and Recipient; this applies to all non-English languages. Written information shall be provided in prevalent languages.

The LME shall give each Enrollee written notice of any "significant change" in the information specified in 42 C.F.R. 438.10(f)(6) and 42 C.F.R. 438.10(g) at least thirty (30) days before the intended effective date of the change. DMA defines "significant change" as change that requires modifications to the Piedmont Waiver or the Medicaid State Plan.

The LME shall notify all enrollees of their right to request and obtain the above information at least once per year.

6.12 Notice of Provider Termination:

The LME shall make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) days after receipt or issuance of the termination notice, to each Enrollee who received services on a regular basis by the terminated provider.

6.13 Care Management:

The LME shall be responsible for the management and continuity of care for Enrollees through the following minimum Care Management functions:

a. 24 hours per day, seven days per week access to telephonic assessment and crisis intervention;
b. Referral to a Network Provider for face-to-face pretreatment assessment, as appropriate, and as consistent with access requirements in Attachment U of this Contract and with 42 C.F.R. Part 438.208;
c. Oversight through Quality Monitoring and the Continuous Quality Improvement Process to ensure individual treatment plan development consistent with 42 C.F.R. Part 438.208 and Part 456 and to ensure Enrollee participation in the treatment planning process;
d. Determination of Medically Necessary Behavioral Health services;
e. Quality Monitoring of the Behavioral Health Services and treatment provided to Enrollees by Network Providers;
f. Coordination of Behavioral Health hospital and institutional admissions and discharges, including discharge planning;
g. Ensure coordination of care with each Enrollee's primary care provider;
h. Provision of follow-up activities to high risk Enrollees who do not appear for scheduled appointments, for individuals for whom a crisis services has been provided as the first service, in order to facilitate engagement with ongoing care and for individuals discharged from 24 hour care;

i. Ensure that in the process of coordinating care, each Enrollee's privacy is protected in accordance with the privacy requirements in 45 C.F.R. Parts 160 and 164 Subparts A and E, to the extent they are applicable;

6.14 Behavioral Health Education Services:

The LME shall make available on an on-going basis the behavioral health education services at convenient times, in accessible locations, and at no cost to the Enrollees and/or the legally responsible persons. Topics shall be based on needs identified by Enrollees, stakeholders and others and shall provide information on referral, education and prevention. Topics shall include subjects such as:

Access to Care
Appeals and Grievances
Recipient Rights
Suicide prevention
Signs of Mental Illness
Risks of substance abuse
Substance abuse prevention

The LME shall keep attendance records of attendees at Behavioral Health Education Activities. The LME shall make the attendance records available for review by DMA and/or the NC DHHS monitoring team during on-site reviews.

6.15 Enrollee Rights:

The LME must have written policies/procedures regarding the rights of Enrollees in accordance with Article 3, Part 1 of N.C.G.S. Chapter 122C and rules promulgated thereunder. The LME must ensure that its staff and Network Providers follow these policies and procedures when furnishing services to Enrollees. Enrollees are free to exercise their rights and the exercise of those rights does not adversely affect the way that the LME or its providers treat the enrollee. Rights include:

a. The right to be treated with respect and due consideration of dignity and privacy.
b. The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.
c. The right to participate in decisions regarding health care, including the right to refuse treatment.
d. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
e. The right to request and receive a copy of his or her medical record, subject to the therapeutic privilege set forth in N.C.G.S. 122C-53(d) and to request that the medical record be amended or corrected in accordance with 45 C.F.R. Part 164 and the provisions of N.C.G.S. 122C-53(d) not inconsistent therewith.

6.16 Anti-gag Clause:

The LME may not prohibit or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient:

a. For the Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
b. For any information the Enrollee needs in order to decide among all relevant treatment options;
c. For the risks, benefits, and consequences of treatment or non-treatment;
d. For the Enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

6.17 Support Services:

The LME shall develop strategies for addressing the special needs of the Medicaid population. Strategies should incorporate staff and Network Provider training to increase awareness and sensitivity to the needs of persons who may be disadvantaged by low income, disability and illiteracy, or who may be non-English speaking. Staff and Network Provider training should include topics such as sensitivity to different cultures and beliefs, the use of bilingual interpreters, the use of Relay NC TTY machines, and other communication devices for the disabled, overcoming barriers to accessing medical care, understanding the role of substandard housing, poor diet, and lack of telephone or transportation for health care needs.

The LME shall provide the following services as necessary to ensure Enrollee access to and appropriate utilization of Medically Necessary services covered under this Contract:

Transportation: The LME shall provide information about the availability of non-emergency transportation for Enrollees through available public and private services. The LME shall provide Enrollees with verbal and written information concerning resources for transportation offered by the Medicaid Program and available in the county.

Interpreter Services: Interpreter services shall be made available by telephone or in-person to ensure that Enrollees are able to communicate with the LME and Network providers. The LME shall make oral interpretation services available free of charge to each potential Enrollee and Enrollee. This applies to non-English languages as specified in C.F.R. 438.10 (c) (5).

Coordination and Referral to Community Resources: The LME shall provide referral to available community services, including but not limited to those identified in Attachment L. The LME shall have staff who are familiar with these resources and shall maintain a written description of appropriate referral procedures.

6.18 Payment to Out-of-Network Providers:

a. The LME shall consider each claim for reimbursement for Emergency Services provided to Recipients by Out-of-Network Providers based upon its own merits and the requirements of this Section, and shall not routinely deny such claims based upon failure to obtain prior authorization;
b. The LME shall reimburse Out-of-Network Providers for Covered Services, which may be obtained by Enrollees without prior authorization from the LME for Emergency Services which could not be provided by an LME Network Provider because the time to reach the LME Network Provider capable of providing such services would have meant risk of serious damage or injury to the Enrollee's health.
c. The LME shall consider each claim for reimbursement for Emergency Services provided to Recipients by Out-of-Network Providers based upon its own merits and the requirements of this Section, and shall not routinely deny such claims based upon failure to obtain prior authorization;
d. The Enrollee may be required to provide information to the LME to assist in proper and prompt payment of services. The LME shall describe in writing the procedures whereby Out-of-Network Providers can appeal claims denied by the LME.
e. The LME shall ensure that cost to the Enrollee is no greater than it would be if the services were furnished within the Network.

6.19 Advance Directives:

The LME shall maintain written policies and procedures concerning Advance Directives as specified in Article 3, Part 2 of N.C.G.S. Chapter 122C.. The LME shall distribute written information regarding Advance Directive policies to adult enrollees, including a description of applicable State and Federal

laws as outlined in Medicaid Special Bulletin on Advance Directives, May 1999 (See Appendix XVII). Written information shall include:

a. Rights under the law of the State;
b. LME policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience;
c. Information on Advance Directive policies of the LME;
d. Description of the State law;
e. The right to file complaints concerning noncompliance with the advance directive requirements with the State Certification and Survey Agency.

The information distributed shall reflect changes in laws as soon as possible, but no later than ninety (90) days after the effective date of the law.

6.20 Payments From Enrollees:

The LME shall not require co-payments, deductibles, or other forms of cost sharing from Medicaid Enrollees for Medicaid services covered under this Contract, nor may the LME charge Enrollees for missed appointments. Enrollees who obtain services from Out-of-Network Providers without LME authorization, except those services specified in Sections 6.3 and 6.19, shall be responsible for payment of costs associated with such services.

Enrollees shall not be held liable for payments to providers or entities:

a. In the event of the LME's or subcontractor's insolvency;
b. In the event that DMA does not pay the PIHP.

6.21 Inpatient Hospital Services:

DMA shall be responsible for reimbursement of inpatient hospital services provided to Enrollees who are inpatients prior to the effective date of their enrollment in the LME, until such Enrollees are discharged from the hospital. For Enrollees who are inpatients on the effective date of enrollment in the LME, the LME shall provide all Covered services, except inpatient and related inpatient services. For Enrollees hospitalized on or after the effective date of enrollment in the LME, the LME shall provide authorization for all covered services, including inpatient and related inpatient services, according to Medical Necessity requirements. The LME shall provide all Covered Services, except inpatient and related inpatient services, to hospitalized Members commencing on the effective date of enrollment. The LME shall provide authorization for all inpatient hospital services to Enrollees who are hospitalized on the effective date of disenrollment (whether voluntary of involuntary) until such Enrollee is discharged from the hospital.

6.22 Confidentiality:

The LME shall adopt and implement policies and procedures to ensure that it complies with all applicable State and federal confidentiality laws, rules, and regulations, including but not limited to:

- N.C. Gen. Stat. § 108A-73 and -80;
- N.C. Gen. Stat. § 122C-52 through -56;
- Subchapter 26B of Title 10A of the North Carolina Administrative Code;
- the Health Information Portability and Accessibility Act (HIPAA);
- the rules that implement HIPAA (45 C.F.R. Parts 160 and 164); and
- 42 CFR §§ 2.1 through 2.67.

SECTION 7 - QUALITY ASSURANCE and QUALITY IMPROVEMENT

7.1 Internal Quality Assurance/Performance Improvement Program

The LME shall establish and maintain a written program for Quality Assurance/Performance Improvement ("QA/PI") consistent with 42 CFR 434.34 and 42 CFR 438.240 and with the utilization control program required by CMS for DMA's overall Medicaid program as described in 42 CFR 456.

The LME shall maintain an active QA/PI committee or other structure, which shall be responsible for carrying out the planned activities of the Quality Assessment/Performance Improvement program. This committee shall have regular meetings, shall document attendance by providers, and shall be accountable and report regularly to the governing board or its designee concerning QA/PI activities. The LME shall maintain records documenting the committee's findings, recommendations, and actions

The LME shall designate a senior executive who shall be responsible for program implementation. The LME's Medical Director shall have substantial involvement in the QA/PI program functions, such as credentialing and utilization review and monitoring of its subcontractors.

The LME shall revise and submit the written Quality Assurance/Performance Improvement program description and a summary of progress toward performance improvement goals to DMA on an annual basis no later than July 31st of each calendar year.

The written program shall describe, at a minimum, how the LME shall:

a. Meet or exceed CMS, DMA, and LME defined minimum performance levels on standardized quality measures annually as described in Attachment N.
b. Develop and implement performance improvement projects using data from multiple sources that focus on clinical and non-clinical areas. These projects must achieve, through ongoing measurements and interventions, demonstrable and sustained improvement in significant aspects of care that can be expected to have a favorable effect on mental health outcomes and enrollee satisfaction.
c. Have in effect mechanisms to detect both over and under utilization of services;
d. Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with mental health care needs;
e. Include all demographic groups, care settings, and types of services in the scope of the review occurring over multiple review periods;
f. Measure the performance of LME providers and conduct peer review activities such as: identification of practices that do not meet Plan standards; recommendation of appropriate action to correct deficiencies; and monitoring of corrective action by providers;
g. Measure provider performance through medical record audits;
h. Provide performance feedback to providers, including detailed discussion of clinical standards and expectations of the LME;
i. Develop and adopt clinically appropriate practice parameters and protocols/guidelines and provide the LME's providers enough information about the protocols/guidelines to enable them to meet the established standards;
j. Evaluate access to care for Enrollees according to Sections 6.4, 6.5 and 6.6 of this Contract, and implement a process for ensuring that network providers meet and maintain these standards. The evaluation should include an analysis of the accessibility of services to Enrollees with disabilities.
k. Quality Assurance Deliverables to DMA
   The LME shall submit the following Quality Assurance, Quality Improvement items to DMA:
   (a) The LME shall develop, implement, and report to DMA a minimum of two (2) plan-specific and self-funded performance improvement projects the first year of this contract; one focusing on a clinical area and one focusing on a non-clinical area. The topics for

these projects shall be jointly determined by the LME and DMA based on statistical reports submitted to DMA the previous year. A required non-clinical performance project for year one (1) of this contract will be the development of an encounter data process that will accurately report services rendered to the enrollees of the LME. Progress summaries of these projects shall be submitted to DMA by July 31st of each calendar year. (See Attachment O). For year two of this contract, the LME shall conduct a performance improvement project in addition to the two planned for the first year of this contract for a total of three. For year three of the contract, the LME shall conduct an additional performance improvement project for a total of four. The project topics shall be jointly determined by the LME and DMA unless mandated by CMS and based on LME performance as measured by annual reporting to DMA;

(b) The LME, at its own expense, shall participate annually in at least one statewide performance improvement project if so directed by DMA;

(c) The LME shall conduct an annual ECHO patient satisfaction survey or other comparable Patient Satisfaction Survey approved by DMA beginning with the second year of the contract utilizing the sampling and format as defined by NCQA. The results of the survey must be filed with DMA as stated in Attachment N, Statistical Reporting Requirements;

7.2 Annual External Quality Reviews

Pursuant to 42 CFR 438 Subpart E, DMA shall contract with an external quality review organization to conduct an annual independent external quality review. Three (3) activities are mandatory during these reviews: 1) determining MCO/PIHP compliance with federal Medicaid managed care regulations; 2) validation of performance measures produced by an MCO or PHIP; and 3) validation of performance improvement projects undertaken by the MCO/PIHP. CMS-published protocols shall be utilized by the organization conducting the external review activities. In addition, the external quality review organization shall conduct an encounter data validation per the CMS protocols every two years beginning in 2006 for dates of service in 2005.

7.3 Inspection and Monitoring:

DMA shall monitor the LME's enrollment practices and the LME's implementation of the LME's Grievance procedures, in accordance with 42 C.F.R. 438.66.

Pursuant to 42 C.F.R. 438.6(g), DMA, the United States Department of Health and Human Services (DHHS) and any other authorized Federal or State personnel or their authorized representatives may inspect and audit any financial records of the LME or its subcontractors relating to the LME's capacity to bear the risk of potential financial losses.

Pursuant to 42 C.F.R. 434.6(a)(5), and as otherwise provided under this Contract, the Department, DMA, and any other authorized Federal or State personnel or their authorized representatives shall evaluate through inspection or other means, the quality, appropriateness and timeliness of services performed under this Contract.

7.4 Utilization Management:

The LME shall have a written Utilization Management Program that is consistent with 42 C.F.R. 456 and 42 C.F.R. 438, Subpart D, and which includes mechanisms to detect underutilization as well as over utilization of services. The written description shall address procedures to evaluate Medical Necessity, clinical criteria used, information sources, and the process used to review and approve the provision of medical services. The LME must ensure consistent application of review criteria for authorization decisions and consult with the requesting provider when appropriate. An annual Utilization Management Plan shall include an annual appraisal that assesses progress in achieving the goals and objectives identified in the prior year. The plan may be combined with the Quality Management Plan and must be submitted to DMA 30 days prior to implementation.

Practice Guidelines: The LME shall develop a Clinical Advisory Committee consisting of professionals from Network Providers. Practice guidelines shall be developed in consultation with this committee. Practice guidelines shall be based on valid and reliable clinical evidence (Evidence Based Practice) or a consensus of professionals in the field. Practice guidelines shall address the needs of Enrollees and shall be reviewed and updated periodically, as appropriate and in accordance with changes and developments in clinical research. Practice guidelines shall be disseminated to affected providers and upon request to Enrollees and Potential Enrollees.

a. The LME shall develop and implement written Utilization Management procedures for each level of care authorized. Decisions for utilization management, enrollee education, coverage of services, and other areas to which Practice Guidelines apply shall be consistent with the Practice Guidelines.
b. Prior and continued stay reviews and denials of authorizations for inpatient and intermediate care shall be conducted by Behavioral Health professionals, as defined in 42 C.F.R Part 456. Prior and continued stay reviews of outpatient services shall be conducted by a licensed Behavioral Health professional. Denials for authorizations for outpatient services shall be conducted or a licensed clinician whose license is at least comparable to the license of the provider of the service in question.
c. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's condition or disease.
d. The LME shall develop and implement processes to monitor utilization of services and to review utilization data to evaluate that services are being provided in a manner consistent with the vision reflected in this document.
e. Adequate data analysis shall be available by the LME's information system to allow such utilization management reviews.
f. The LME shall include in its provider contracts with individual, group, and organizational providers a requirement to comply with Federal, State, and LME requirements regarding access to care, utilization review, clinical studies and other utilization management, Care Management, Quality Management and credentialing activities prescribed in 42 C.F.R. parts 441 and 456. The LME shall develop policies and procedures for monitoring provider compliance with these requirements.
g. The LME is prohibited from implementing Utilization Management procedures that provide incentives for the individual or entity conducting utilization reviews to deny, limit, or discontinue Medically Necessary Services to any Enrollee.
h. Timeframes for Standard Authorization Decisions or Standard Authorization Denial: Notice must be provided as expeditiously as the Enrollee's health condition requires, but may not exceed 14 calendar days following receipt of the request for services, with a possible extension of up to 14 additional calendar days if the enrollee or the provider requests extension, or the LME documents a need to DMA for additional information and that the extension is in the Enrollee's interest.
i. Timeframes for Expedited Authorization Decisions or Expedited Authorization Denials: For cases in which a provider indicates, or the entity determines, that following the standard timeframe could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the entity shall make an expedited decision and provide notice as expeditiously as the Enrollee's health condition requires, but no later than 3 working days after receipt of the request for service. The LME may extend the 3 working days time period by up to 14 calendar days if the Enrollee requests an extension or if the LME documents a need to DMA (if requested by DMA) a need for additional information and how the extension is in the Enrollee's interest.
j. Timeframes for notice of action for Termination, suspension or reduction of services. The LME shall provide at least 10 days before the date of action when the action is a termination, suspension, or reduction of previously authorized Medicaid-covered services except that the period of advanced notice is shortened to 5 days if probably recipient fraud has been verified.

Notices to Enrollees shall be in accordance with 42 C.F.R. 438.210 (c). See Attachment P, Grievance Procedures.

7.5 Grievance Procedure:

The LME shall have a timely and organized system with written policies and procedures for resolving internal Grievances in accordance with 42 C.F.R. 438.228, 42 C.F.R. 438 Subpart F, and the requirements set forth in Attachment P, that:

a. Is approved in writing by DMA;
b. Provides for prompt resolution; and
c. Assures the participation of individuals with the authority to require corrective action.

Tracking and analysis of Grievance and Appeal data shall be used by the LME for quality improvement. All Enrollee Grievances, and Appeals shall be reported by number and type and with action taken for resolution. Reports shall be submitted no later then forty five (45) calendar days after the end of a fiscal quarter. The LME shall comply with requirements for grievance procedures Attachment P Grievance Procedures.

7.6 Credentialing:

The LME shall have written policies and procedures for provider credentialing, re-credentialing, initial qualification, accreditation, and re-accreditation, in accordance with Community Standards in care and service provision, and the rules and standards of the Department The LME shall implement its policies and procedures for credentialing, re-credentialing, provider qualification, accreditation and re-accreditation with providers with which it has signed contracts or participation agreements. Such providers fall under its scope of authority and action under the terms of this Contract and for all services provided under the 1915(b) waiver. The LME shall maintain credentialing, qualification and accreditation records that demonstrate compliance with its policies and procedures. These records shall be made available to DMA during business hours. The credentialing, re-credentialing, accreditation, and re-accreditation criteria shall be consistent with State and Federal regulations governing the professional areas for those providers. The LME shall monitor licensed, certified, registered or accredited providers for continued compliance with these criteria. DMA shall review and approve the LME's provider credentialing, re-credentialing, initial qualification, accreditation and re-accreditation process prior to implementation.

a. The LME shall establish yearly thresholds for insurance coverage and require and ensure that providers obtain and maintain appropriate levels of insurance coverage in the following areas:
   1. General Liability
   2. Automobile Liability
   3. Worker's Compensation and Employer's Liability
   4. Professional Liability

   Insurance policies shall require that the required coverage cannot be suspended, voided, canceled or reduced in coverage or in limits without 30 days prior notice to the LME. Network providers shall provide certificates of coverage to the LME. The certificates of coverage shall be made available to DMA upon request.

b. Providers shall not be restricted or inhibited in any way from communicating freely with or advocating for persons regarding behavioral health care, medical needs, treatment options, any information the Recipient needs to decide among relevant treatment options, the risks benefits and consequences of treatment or non-treatment, and the Recipient's right to participate in decisions regarding his or her Behavioral Health care, including the right to refuse treatment and express preferences about future treatment decisions.

c. If the LME declines to include individual providers or provider agencies in its network, it shall give the affected providers written notice of the reason for its decision. If the LME is at capacity in professional services or type of services provided by a provider not in its network, it is not obligated to conduct qualification, credentialing or accreditation reviews of providers requesting to join its network.

d. The LME shall monitor provider performance and shall consider information from its monitoring activities, Utilization Management Program on over- and under-utilization, Quality Management Program, accreditation outcomes, Grievance, Appeal, Complaint logs, Enrollee satisfaction surveys, and other quality improvement in decisions to re-accredit and re-credential providers for its network. The criteria for participation must be applied consistently for all providers.

7.7 Provider Selection:

The LME shall have written policies and procedures for the selection and retention of Network Providers. Qualification of providers shall be conducted in accordance with the procedures delineated in Attachment Q. The LME shall not discriminate, solely on the basis of the provider's license or certification, for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, If the LME declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for its decision.

In all contracts with health care professionals, the LME shall comply with the requirements specified in 42 C.F.R. 438.214 which includes, selection and retention of providers, credentialing and re-credentialing requirements and non-discrimination. The LME shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The LME shall not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act. The LME shall consult the Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities (LEIE), the Medicare Exclusion Databases (MED) and the Excluded Parties Listing System (EPLS) to ensure that providers who are excluded from participation in Federal programs are not enrolled in the LME network.

The LME is not precluded from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to enrollees.

The LME will monitor provider performance and will consider information from its monitoring activities, Utilization Management Program on over-and-under utilization, Quality Management Program, program inspections, Grievance, Appeal, Complaint information, Enrollee satisfaction surveys, and other quality indicators in decisions to qualify, re-qualify, and re-enroll providers in its network.

7.8 Provider Manual:

The LME shall develop, maintain, and distribute a provider manual that provides information and education to providers about the LME. This distribution may occur by making the manual available electronically or on its website. At a minimum, the provider manual shall cover the areas listed below. DMA shall have the right to review and approve the provider manual prior to its release. The manual shall be updated at least annually.

a. Purpose and mission
b. Treatment Philosophy and Community Standards of Practice

c. Behavioral health provider network requirements including nondiscrimination, on call coverage, credentialing, re-credentialing, access requirements, no-reject requirements and notification of changes in address, licensure, insurance requirements, or required availability.
d. Appointment access standards
e. Authorization, utilization review and care management requirements.
f. Care Coordination and discharge planning requirements.
g. Documentation requirements as specified in APSM 45-2, or as required by the Physician's Services Manual
h. Provider appeals process
i. Complaint investigation and resolution procedures
j. Performance improvement procedures including Recipient satisfaction surveys, provider satisfaction surveys, clinical studies, incident reporting, outcomes requirements, etc.
k. Compensation and claims processing requirements, including required electronic formats, mandated timelines, and coordination of benefits requirements.
l. Patient rights and responsibilities.

The LME shall provide training and technical assistance it deems necessary to providers regarding administrative and clinical procedures, and requirements, as well as clinical practices.

7.9 Health Information Systems:

The LME shall maintain a health information system that collects, analyzes, integrates, and reports data. The system shall provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.

The LME shall collect data on enrollee and provider characteristics as specified by DMA and on services furnished to Enrollees through an encounter data system or other methods as may be specified by DMA.

The LME shall collect service utilization data for trend analysis and benchmarking to establish long-term validity and accuracy.

The LME shall collect service information in standardized formats to the extent feasible and appropriate.

The LME shall ensure that data received from providers is accurate and complete by:

a. Verifying the accuracy and timeliness of reported data; and
b. Screening the data for completeness, logic, and consistency.

The LME shall make all collected data available to DMA and upon request to CMS.

SECTION 8 - RECORDS

8.1 Clinical Records:

Network Provider Medical Records: The LME shall set standards for the maintenance of clinical records for network providers incorporating *The Service Records Manual* (APSM 45-2) and APSM 30-1 or the *Physician's Services Manual*, as applicable. Medical Records shall be maintained at the provider level; therefore patients may have more than one record, if multiple providers are providing services. The LME shall monitor the Medical Record documentation to ensure that the standards are met. The LME shall have the right of inspection of provider records without notice. LME contracts shall contain a provision that original Medical Records are forwarded to the LME upon closure of the

Network Provider's North Carolina business operations, whether due to bankruptcy, moving business operations to another state or for any other reason.

LME Service Management Records: The LME shall maintain all Service Management Records in accordance with this agreement and with all specifications for record keeping established by DMA for purposes of audit and program management. All books and records shall be maintained to the extent and in such detail as shall properly reflect each service provided. The LME may maintain records in an electronic format.

Documentation for all Enrollees:

a. Demographic information, including:
   1. Name
   2. Medicaid ID number
   3. Birth date
   4. Sex
   5. Address and phone number
   6. Parent or guardian if under 18

b. Referral or Care Management contact information:
   1. Date of the contact
   2. Service requested
   3. If the requested service meets medical necessity:
      - Amount, duration, and scope authorized
      - Basis or information used for the medical necessity determination

c. If the requested service does not meet medical necessity:
   1. The rationale for the denial indicating criteria or benefits provision used
   2. The proposed alternative service that does meet medical necessity for the individual, if any
   3. Notice of adverse action, including the timetable and method for informing the Enrollee and provider of the denial, reduction, or termination of the authorization for the requested service and the Enrollee Grievance and Appeal rights
   4. Documentation that the denial of the authorization was made by a physician or practitioner operating within the scope of his/her license.

d. Name and credentials of the individual conducting the review

e. Name, signature and credentials of the individual conducting the denial, reduction or termination of the authorization for the requested service.

f. Record of services authorized by the LME and billed by Network Providers.

Additional information to be obtained as appropriate:

a. For 24 hour care:
   1. Date of admission
   2. Date of discharge
   3. For inpatient discharges, evidence of an appropriate discharge plan
   4. For inpatient discharges, follow up authorization for outpatient care.

b. As appropriate to the individual consumer, coordination of care information which may include:
   1. Name of primary care physician or other key providers
   2. Other systems of care involved such as educational system, Department of Social Services, Criminal Justice.

c. In the presence of risk factors, evidence of education, outreach and follow up as appropriate for the individual.

8.2 Financial Records:

The LME or Network Providers shall maintain detailed records of the administrative costs and expenses incurred pursuant to this Contract including provision of Covered Services and all relevant information relating to individual Enrollees for the purpose of audit and evaluation by DMA and other Federal or State personnel. Records shall be maintained in compliance with all State and Federal requirements including HIPAA for use in treatment, payment or operations. Records shall be maintained and available for review by authorized Federal and State personnel during the entire term of this Contract and for a period of five (5) years thereafter, unless an audit is in progress. When an audit is in progress or audit findings are unresolved, records shall be kept until all issues are finally resolved.

8.3 Access to Records:

All disclosure of records shall be performed in compliance with the HIPAA Privacy Standards. Any records requested pursuant to monitoring, audit or inspection as called for in this Contract shall be produced immediately for on-site review or sent to the requesting authority by mail within fourteen (14) days following the request. The LME Network Provider Contract shall contain provisions requiring all Network Providers to comply with requests for information and that all requested records shall be provided to DMA within fourteen (14) days, at the sole cost and expense of the Network Provider. DMA shall have unlimited rights to use, disclose, and duplicate information and data developed, derived, documented, or furnished by the LME and in any way relating to this Contract.

SECTION 9 - REPORTS AND DATA

9.1 Enrollment Report:

DMA shall provide to the LME a monthly Enrollment Report no earlier than the fourth to the last working day before the end of each month and no later than the first day of the ensuing month. The enrollment report shall list all Medicaid recipients who will be enrolled in the LME during the ensuing month. The list of Medicaid re-ups shall serve as the basis for the ensuing month's capitated payment to the Plan.

DMA shall pay the LME a capitated payment for each enrollee listed on the report according to the rates calculated as specified in Attachment R. All enrollments and disenrollments shall be effective on the first day of the calendar month for which the enrollment or disenrollment is listed on the electronic data file. The LME shall bill DMA fee-for-service for services provided to new or re-enrolled Medicaid recipients during the interim period between establishing or re-establishing Medicaid eligibility and enrolling the recipient in the LME.

9.2 Encounter Data:

The LME shall submit to DMA an electronic record of every encounter between a network provider and an Enrollee within fifteen (15) days of the close of the month in which the specific encounter occurred, was paid for, or was processed, whichever is later, but no later than 180 days from the encounter date. DMA shall conduct validation studies of encounter data, testing for timeliness, accuracy and completeness. The LME shall report all encounters that occur up to the date of termination. The LME is subject to sanctions for late or incomplete submissions in accordance with Section 14. If the contract terminates while payments are being withheld by DMA due to inaccurate or late reporting of encounter data, DMA shall continue the withhold until the LME reports all encounter data according to the Attachment X, Financial Reporting Requirements.

9.3 Reporting Requirements:

Within 60 days after the end of each fiscal year quarter, and 90 days after the end of the Fiscal Year, financial reports shall be submitted in accordance with the Reporting Requirements delineated in Attachment X. The LME is responsible for submitting financial reports that are timely, accurate, and complete. The submission of late, inaccurate, or otherwise incomplete reports shall constitute a failure to report and the LME shall be subject to corrective actions or Penalties and Sanctions as specified in Section 14. DMA shall furnish the LME with timely notice of reporting requirements, including acceptable reporting formats, instructions, and timetables for submission and such technical assistance in filing reports and data as may be permitted by the DMA's available resources. DMA reserves the right to modify from time to time the form, content, instruction, and timetables for collection and reporting of data. DMA agrees to involve the LME in the decision process prior to implementing changes in format, and shall request the LME to review and comment on format changes before they go into effect. The timetable for new reports shall be negotiated by the LME and DMA, taking into consideration the complexity and availability of the information needed.

Timelines: Reports or other data shall be received on or before the scheduled due date. All required reports shall be received by DMA no later than 5:00 p.m. Eastern Time on the due date. Requests for extensions shall be submitted to DMA in writing. All reports remain due on the stated schedule unless DMA shall approves the extension request in writing.

Network Providers who provide services under the Contract shall have a unique identifier.

9.4 Fraud and Abuse:

The LME shall have administrative and management arrangements or procedures designed to guard against fraud and abuse. The LME arrangements and procedures shall include the following:

a. A procedure to verify whether services reimbursed by Medicaid were actually furnished to Enrollees by providers and subcontractors;
b. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and State standards;
c. The designation of a compliance officer and a compliance committee that are accountable to senior management;
d. Effective training and education for the compliance officer and the organization's Employees;
e. Effective lines of communication between the compliance officer and the organization's Employees;
f. Enforcement of standards through well-publicized disciplinary guidelines;
g. Provision for internal monitoring and auditing;
h. Provision for prompt response to detected offenses, and for development of corrective action initiatives.

The LME shall have a mandatory Compliance Plan designed to guard against fraud and abuse. If the LME receives or identifies what appears to be a complaint of fraud and abuse from any source or identifies any questionable practices, it shall forward the information to DMA. For each case of reasonably substantiated suspected provider fraud and abuse the LME shall provide DMA with the provider's name and number, the source of the complaint, the type of provider, the nature of the complaint, the approximate range of dollars involved, and the legal and administrative disposition of the case. For each case of reasonably substantiated (suspected) enrollee fraud and abuse the LME shall provide DMA with the recipient's name and number, and the source and nature of the compliant. DMA shall conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation.

9.5 Financial Reports:

Within sixty (60) days of the end of each state fiscal quarter, financial data shall be reported as required in Attachment X.

All information, reports and data, including but not limited to encounter data, which this contract requires the LME to submit to DMA shall be certified as set forth in 42 C.F.R. 438.606. The certification shall be made by one of the following individuals:

a. The LME's Chief Executive Officer;
b. The LME's Chief Financial Officer; or
c. An individual who has been authorized to sign for, and who reports directly to, the LME's Chief Executive Officer or Chief Financial Officer.

The certification shall attest based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data. The LME shall submit the certification concurrently with the certified data and documents.

SECTION 10 - PAYMENTS TO THE LME

10.1 Monthly Payment: :

Capitated payments shall be made on a Per Member Per Month (PMPM), prospective and pre-paid basis at the first check-write of each month. The check-write schedule is provided on the DMA website at www.dhhs.state.nc.us/dma/prov.htm under the "Publications" heading. Monthly payments shall be finalized based on quarterly analysis and reconciliation to Medicaid eligibility data. In full consideration of all services rendered by the LME under this Contract, DMA shall remit to the LME the Capitation Rate calculated as specified in Attachment R by multiplying the number of Medicaid Eligibles in each Rate Cell, whose county of residence for Medicaid purposes is within the LME's geographic area as determined by the monthly cutoff date in DMA's Medicaid Eligibility data system, by the payment rates for the respective Rate Cells. However, payments provided for under the contract shall be denied for new Enrollees when, and for so long as, payment for those Enrollees is denied by CMS in accordance with the requirements at 42 C.F.R. 438.730. Payments made by DMA pursuant to this Contract are conditioned upon the availability to DMA of funds authorized for expenditure in the manner and for the purposes provided herein. DMA shall not be liable for any purchases or subcontracts entered into by any subcontracted provider in anticipation of funding.

In accordance with the rate setting methodology, individuals are considered a year older on the first day of the month following their birthday, regardless of the person's day of birth. For example, a person born August 30, 2002 shall be considered 1 year old on September 1, 2003. As Enrollees transition into different rate bands due to age, the new rate is effective on the first of the month following the month in which the person was born.

The payment is contingent upon satisfactory performance by the LME of its duties and responsibilities as set forth in this Contract. All payments shall be made by electronic funds transfers. The LME shall set up the necessary bank accounts and provide written authorization to DMA's Fiscal Agent to generate and process monthly payments through the internal billing methods, in form and substance designated by DMA.

The LME shall not use Title XIX funds to pay for services or administration related to non-Title XIX clients or non-Title XIX services to Title XIX clients. The LME shall maintain separate accounting for revenue and expenses for the Title XIX program in accordance with CMS requirements as delineated in Attachment X.

10.2 Payment in Full:

The LME shall accept the capitation rate paid each month by DMA , including retroactive payments and adjustments as described in Section 10.1, as payment in full for all services to be provided pursuant to this Contract, including all administrative costs associated therewith. Enrollees shall be entitled to receive all covered services for the entire period for which payment has been made by DMA. Interest generated through investment of funds paid to the LME pursuant to this Contract shall be the property of the LME.

10.3 Retroactive Payment Adjustments:

DMA shall make retroactive capitated payments for 1915(c) Innovations waiver participants when recipients are determined to be eligible for participation in the Innovations waiver retroactively. When non-Innovations waiver participants are determined to be eligible for Medicaid retroactively, the LME shall bill Medicaid fee-for-service for any covered MH/DD/SA services provided by the LME during the retroactive period.

Payment adjustments may be initiated by DMA when keying errors or system errors affecting correct capitation payments to the LME occur. Each payment adjustment transaction shall be included on the remittance advice in the month following the correction. Each transaction shall include identifying Enrollee information and the payment adjustment amount.

10.4 Calculation of Rates:

The LME and DMA shall negotiate capitation rates in good faith. These rates shall be certified as compliant with the Centers for Medicare and Medicaid Services requirements under 42 C.F.R. 438.6(c) by actuaries meeting the qualification standards of the American Academy of Actuaries.

The actuary for DMA shall develop capitation rate ranges in accordance with CMS regulations for the populations and services covered under the managed care contract. DMA reserves the right to determine and/or adjust these populations and services covered under this contract prior to each year. The State Fiscal Year (SFY) of July 1 through June 30 shall be used.

Reimbursement provided under this Contract is intended for the coverage of Medically Necessary services covered under the North Carolina State Plan, as well as those services identified under section 1915(b)(3) of the CMS approved Piedmont waiver and the section 1915 c Innovations waiver. The Piedmont LME has the ability to utilize this reimbursement to provide Medically Necessary service in place of, or in addition to, the services covered under the State Plan, in order to meet the needs of the individual Enrollee in the most efficient manner. However, since the capitation rates cannot include these additional services, an adjustment may be required in the rate development process to incorporate the costs of State Plan services that would have been provided in the absence of alternative or additional services.

Annual financial data, including the LME's annual audit shall be provided within 90 days following the end of the LME's fiscal year.

Attachment R indicates projected rates and the capitation rates applicable to each Eligibility group for the initial year of this Contract. Rates shall be recalculated using the methodology in Attachment R. Using this methodology, rates shall be recalculated each year and the LME shall be notified by May 1 of the new rates to be effective July 1 of the next year. The LME shall have sixty (60) days to review the proposed rates. At the end of the sixty (60) day review period the LME may choose to terminate the contract with DMA. The LME shall be required to provide a sixty day (60) written notification.

10.5 Rate Adjustments:

Substantive changes in Medicaid services may occur during the contract year due to Medicaid Program policy or mandated legislative changes. If DMA requires the LME to provide additional services in the contract year, DMA shall make an adjustment to the capitation rate. Similarly, if DMA requires the LME to provide fewer services in the contract year, DMA shall make an adjustment to the capitation rate.

10.6 Recoupment:

If the LME fraudulently reports, knowingly fails to report, or errs intentionally or unintentionally in reporting information regarding payments, DMA may request a refund of, or it may recoup from subsequent payments, any payment previously made to the LME.

DMA may recoup payments made to the LME when keying errors or system errors affecting correct capitation payments occur. Each recoupment transaction shall be included on the remittance advice in the month following the correction. Each transaction shall include identifying Enrollee information and the recoupment amount.

10.7 Third Party Resources:

The capitated rates set forth in this Contract have been adjusted to account for the primary liability of third parties to pay for some of the services rendered to Enrollees. The LME shall make every reasonable effort to determine the liability of third parties, including casualty and other tort liability, to pay for services rendered to Enrollees pursuant to this Contract and to assign Coordination of Benefits responsibility to Network Providers. All funds recovered by the LME from third party resources shall be treated as income to the LME.

The LME shall contractually require its Network Providers to report any third party coverage of its Members to DSS within five (5) days of obtaining the information from a source other than DSS.

If the LME does not identify and/or collect third party resources within 12 months from the date of service, DMA may collect and retain any third party recoveries that it should discover.

10.8 Savings:

In the event that the costs of serving individuals through the Piedmont 1915(b)/(c) "Innovations" waiver program are less than the amount of the capitated payments for the 1915(c) waiver participants, the LME and the DMA agree that:

a. The amount saved shall be used to increase the number of individuals receiving the Innovations waiver services in order to reduce the LME waiting list;
b. The capitation payments for participants in the Innovations waiver shall be limited to 440 waiver participants per month in the first year of the waiver.
c. The LME shall track and report expenditures for the individuals receiving waiver services above the 440 slots separately.
d. For the future years of the contract, DMA shall review the number of individuals receiving waiver services and shall adjust the number of 1915(c) waiver slots accordingly.

In the event that the costs of serving individuals participating in only the 1915(b) waiver program are less than the amount of the capitated payments for the 1915(b) waiver participants, the LME and DMA agree that:

a. The waiver shall be amended as soon as practicable to add 1915(b)(3) services that mirror the services in the 1915(b)/(c) Innovations waiver.
b. These services shall be funded by savings obtained through the LME's decreasing the utilization of ICF/MR services, including services furnished by the State MR centers.
c. Expenditures for the referenced 1915(b)(3) services shall be limited to the amount not expended on ICF/MR services as a result of the LME's efforts to reduce ICF/MR utilization.
d. The LME shall employ the amount saved by virtue of reducing ICF/MR utilization to: (1) provide Piedmont Innovations services, or appropriate 1915 (b) (3) services, to persons placed in the community from the ICF/MR; and (2) to the extent practicable, other persons in the community who qualify for Piedmont Innovations services but have been wait-listed.

SECTION 11 - SUBCONTRACTS

11.1 Requirements:

The LME may enter into subcontracts for the performance of its administrative functions or for the provision of various Covered Services to Enrollees. The LME shall obtain the approval of DMA prior to sub-contracting any administrative functions. The LME shall evaluate a prospective subcontractor's ability to perform the activities to be delegated. The LME shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a

periodic schedule consistent with industry standards. The LME shall identify deficiencies or areas for improvement in the subcontractor's performance and require the subcontractor to take corrective action.

Each subcontract for administrative functions that are the responsibility of the LME, and any amendment to a subcontract, shall be in writing and approved in writing by DMA. All subcontracts shall fulfill the requirements of 42 C.F.R. 438.6 and 42 C.F.R. 434.6 that are appropriate to the service or activity delegated under the subcontract. The subcontract shall specify the activities and report responsibilities delegated to the subcontractor and provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

The LME shall not sign a contract with any subcontractor that is not eligible for participation in the Medicaid program. The LME shall bind all of its subcontractors to all of the terms of this prime contract and to all of the terms of all applicable Federal and State laws and regulations. No subcontract shall in any way relieve the LME of any responsibility for the performance of its duties under this Contract. All subcontracts shall clearly identify the functions that are subcontracted. Upon DMA's request, the LME shall provide DMA with copies of the results of any audits or reviews of the performance of the LME's subcontractors. All subcontracts shall:

a. Identify the population covered by the subcontract;
b. Specify the amount, duration and scope of services to be provided by the subcontractor;
c. Specify procedures and criteria for extension, re-negotiation and termination;
d. Make full disclosure of the method and amount of compensation or other consideration to be received from the LME;
e. Provide for monitoring by the LME of the quality of services rendered to Enrollees;
f. All subcontracts shall provide that the LME shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards;
g. All subcontracts shall contain a provision that upon the LME's identification of deficiencies or areas for improvement in the subcontractor's performance, the subcontractor shall take corrective action;
h. Contain no provision which provides incentives, monetary or otherwise, for the withholding from Enrollees of Medically Necessary Services;
i. Contain a prohibition on assignment or any further subcontracting without the prior written consent of the LME; and
j. Incorporate all provisions of this Contract to the fullest extent applicable to the service or activity delegated pursuant to the subcontract, including without limitation, the obligation to comply with all applicable Federal and State laws and regulations, all rules, policies and procedures of the Department and DMA, and all standards governing the provision of Covered Services and information to Enrollees; all quality assurance requirements; all record keeping and reporting requirements; the obligation to maintain the confidentiality of information; all rights of DMA and other officials to inspect, monitor and audit operations; the rights of DMA and other State/Federal officials to inspect and audit any financial records; all indemnification and insurance.

11.2 Timeliness of Provider Payments:

Payments to providers by the LME shall be made on a timely basis, consistent with claims payment procedures described in Section1902(a)(37)(A) of the Social Security Act and 42 C.F.R. 447.45. The LME shall ensure that ninety percent (90%) of all Clean Claims for covered services, for which no further written information or substantiation is required in order to make payment, are paid within thirty (30) days of the date of approval; and that ninety nine percent (99%) of such claims are paid within one hundred eighty (180) days of the date of receipt. Additionally, the LME is not responsible for processing or payment of claims that are submitted after 90 days of the date of service. Date of receipt is the date the LME receives the claim, as indicated by electronic data records and the 835

Health Care Claim Payment/Advice Transaction (Electronic Remittance Advice [ERA]) generated for the provider. The date paid is the date of the check or other form of payment.

The LME shall follow North Carolina Prompt Pay Requirements as follows: Within eighteen (18) calendar days after the LME receives an invoice/claim from a provider, the LME shall either (a) approve payment of the invoice/claim, (b) deny payment of the invoice/claim, or (c) determine that additional information is required for making an approval or denial. If payment is approved, the claim shall be paid within 30 calendar days after it is approved. If the LME fails to pay providers within these parameters, the LME shall pay to the providers interest in the amount of 8% beginning on the date following the day on which the payment should have been made.

11.3 DMA's Remedies Against Subcontractors:

DMA shall have the right to invoke against any subcontractor under this Contract remedies available under this Contract including inspection of records, termination of Contract, requirement of establishment plan of correction, stop payment, and recoupment of payments.

SECTION 12 - DEFAULT AND TERMINATION

12.1 LME Breach, Remedies:

If the LME fails to fulfill its duties and obligations pursuant to this Contract, DMA may issue a written notice to the LME indicating the violation(s) and requiring the submission of a corrective action plan, within thirty (30) days, that is subject to the approval of DMA. Failure to correct the violation(s) to the satisfaction of DMA may lead to the imposition of all or some of the sanctions listed below:

a. Suspension, recoupment, withholds of the monthly capitation payments or assessment of non-refundable or refundable penalties;
b. Termination of this Contract; or
c. Liquidated damages

Notwithstanding the foregoing, DMA may impose any sanction available to it under this contract without first giving the LME an opportunity to cure the deficiency.

See Attachment Y for Medicaid Penalties.

12.2 Option to Terminate:

This Contract may be terminated without cause by either party upon ninety (90) days prior written notice to the other party. Termination shall be effective only at midnight of the last day of a calendar month. In the event of termination, DMA shall work with the LME to minimize disruption of services to clients. If the LME exercises its right to terminate this contract without cause, DMA may require the LME to pay the non-federal share of transition (cost of EIS, MMIS and recipient notifications) In the event that either party exercises its right to terminate this contract without cause, the LME shall perform all of the duties specified in Section 13.5, below, and shall pay DMA in full any refunds or other sums due DMA under to this Contract.

DMA has the authority to terminate the contract and provide enrollees their Medicaid benefits through other options in the State Plan if DMA determines that the LME has failed to do either of the following:

a. Carry out the substantive terms of this contract; or
b. Meet applicable requirements in sections 1932, 1903(m), and 1905(t) of the Social Security Act.

12.3 Grounds for Immediate Termination:

DMA shall have the right to immediately terminate this Contract upon the occurrence of any of the following events:

a. The LME, its subcontractor, or suppliers violate, or fail to comply with, any applicable provision of Federal or State law or regulation;
b. The performance of the LME or of any of the LME's Network Providers threatens to place the health or safety of any Enrollee in jeopardy and the LME fails to take appropriate action to immediately correct the problem;
c. The LME becomes subject to exclusion from participation in the Medicaid program pursuant to Section 1902(p)(2) of the Act (42 U.S.C. 1396 a (p));
d. The LME fraudulently misleads any Enrollee or fraudulently misrepresents the facts or law to any Enrollee;
e. Gratuities of any kind are offered to or received by any public official, employee or agent of the State by or from the LME, its agents, employees, subcontractors or suppliers.
f. Either of the two sources of reimbursement for Medical Assistance, appropriations from the North Carolina General Assembly and appropriations from the United States Congress , no longer exists, or in the event that the sum of all obligations of DMA, including without limitation, all Statements of Participation entered into pursuant to the State LME, equals or exceeds the balance of such sources available to DMA for "Medical Assistance Benefits" for the contract year in which this Contract is effective, less One Hundred Dollars ($100.00), then this Contract shall immediately terminate without further obligation of the Division of Medical Assistance as of that moment.

Certification by the Director of the Division of Medical Assistance of the occurrence of any of the events stated above shall be conclusive. The Division of Medical Assistance shall attempt to provide the LME with ten (10) days notice of the possible occurrence of events described in Subsection (f) of this Section.

12.4 Obligations Upon Termination:

Upon termination of this Contract, the LME shall be solely responsible for the provision and payment for any medically necessary covered services needed by the enrollees, for the remainder of any month for which DMA has paid the monthly capitation rate. Upon termination of this Contract, the LME shall:

a. Continue providing authorizations for Covered Services to all Enrollees until midnight on the last day of the calendar month for which a capitated rate payment has been made by DMA;
b. Continue providing authorization for inpatient Hospital Services and any services directly related to inpatient care, to any Enrollees who are hospitalized on the termination date, until each Enrollee is discharged;
c. Provide DMA with a report of all active authorizations with authorization limits;
d. Provide DMA with a list of Inpatients and where hospitalized;
e. Provide DMA with a list of PRTF patients and where hospitalized;
f. Arrange for the transfer of patients to other appropriate Medicaid Providers;
g. Promptly supply to DMA information on all outstanding claims and arrange for the payment of such claims;
h. Take such action as may be necessary, or as DMA may direct, for the protection of property related to this Contract, which is in the possession of the LME and in which DMA has or may acquire an interest;
i. Provide for the maintenance of all records for audit and inspection by DMA, CMS and other authorized government officials, in accordance with Section 8 of this Contract;
j. Provide for the transfer of all data, including encounter data and records, to DMA or its agents as may be requested by DMA;

k. Provide for the preparation and delivery of any reports, forms or other documents to DMA as may be required pursuant to this Contract or any applicable policies and procedures of DMA; and
l. Notify Enrollees of contract termination in writing forty five (45) days or more prior to the termination date. The notification letter shall be approved by DMA.

The obligations set forth in this Section shall survive the termination of this Contract and shall remain fully enforceable by DMA against the LME. In the event that the LME fails to fulfill each obligation set forth in this Section, DMA shall have the right, but not the obligation, to arrange for the provision of such services and the fulfillment of such obligations, all at the sole cost and expense of the LME and the LME shall refund to DMA all sums expended by DMA in so doing.

SECTION 13 – PENALTIES, SANCTIONS and TEMPORARY MANAGEMENT:

DMA may use any of the following options to ensure compliance with the provisions outlined in this Contract:

1. Corrective Action Plan: To be developed by the LME based on out-of-compliance issues. The Plan shall require approval by DMA, and shall be monitored by the Monitoring Team and DMA (Section 1.7: Monitoring Process)
2. Penalties and Sanctions: (Specified in Section 13.1 of this Contract - LME Penalties, and Section 13.2 of this Contract - LME Sanctions; and Appendix XVI);
3. Temporary Management: (Specified in Section 13.3 of this Contract - Temporary Management);
4. Termination: (Section 12, Default and Termination).

13.1 Monetary Penalties

If the LME does not adhere to reporting and data submission requirements and deadlines stipulated within this contract, DMA may impose penalties as described in Attachment Y, Penalties.

In subsequent financial data reports, all financial penalties shall be reflected that have been imposed by either the terms or conditions of this contract, DMA policy, applicable law, or regulation. Non-compliance with data reporting requirements stipulated in this contract is grounds for contract termination. DMA shall communicate the penalties in writing to the LME and DMA's fiscal agent.

DMA shall have the right to assess penalties, pursuant to Section 12.2, Timeliness of Provider Payments and Section 9.3 Reporting Requirements. Refer to Attachment Y for Penalty schedule.

13.2 Sanctions

DMA may impose sanctions authorized by 42 C.F.R. 438.702.

For any of the violations under paragraphs 42 C.F.R. 438.700(d)(1) and (d)(2), only the sanctions specified in 42 C.F.R. 438.702, paragraphs (a)(3), (a)(4), and (a)(5) may be imposed.

13.3 Temporary Management

DMA shall impose temporary management (regardless of any other sanction that may be imposed) if it finds that the LME has repeatedly failed to meet substantive requirements in section 1903(m) or section 1932 of the Social Security Act.

DMA may not delay imposition of temporary management in order to provide a hearing before imposing this sanction. DMA may not terminate temporary management until it determines that the LME can ensure that the sanctioned behavior shall not recur.

Attachment C

BACKGROUND, PURPOSE AND GOALS

PURPOSE:

The purpose of the North Carolina-Piedmont Demonstration Project is to actualize the Mission and Vision of North Carolina's Blueprint for Change, which is the DMH/DD/SAS State Plan outlining system reform.

MISSION:

North Carolina shall endeavor to provide people with, or at risk of, mental illness, developmental disabilities and substance abuse problems and their families the necessary prevention, intervention, treatment, services and supports they need to live successfully in communities of their choice.

VISION:

1. Public and social policy toward people with disabilities shall be respectful, fair and recognize the need to assist all that need help.

2. The state's service system for persons with mental illness, developmental disabilities and substance abuse problems shall have adequate, stable funding.

3. System elements shall be seamless: consumers, families, policymakers, advocates and qualified providers shall unite in a common approach that emphasizes support, education/training, rehabilitation and recovery.

4. All human service agencies that serve people with mental health, developmental disabilities, and/or substance abuse problems shall work together to enable consumers to live successfully in their communities.

5. Within this vision, Consumers shall have:

    a. Meaningful input into the design and planning of the services system;
    b. Information about services, how to access them and how to voice complaints;
    c. Opportunities for employment in the system;
    d. Easy, immediate access to appropriate services;
    e. Educational, employment or vocational experiences that encourage individual growth, personal responsibility and enjoyment of life;
    f. Safe and humane living conditions in communities of their choice;
    g. Reduced involvement with the justice system;
    h. Services that prevent and resolve crises;
    i. Opportunities to participate in community life, to pursue relationship with others and to make choices that enhance their productivity, well being and quality of life;
    j. Satisfaction with the quality and quantity of services; and
    k. Access to an orderly, fair and timely system of arbitration and resolution.

6. Within this vision, Providers and Care Managers shall have:

    a. The opportunity to participate in the development of a state system that clearly identifies target groups, core functions and essential service components;
    b. Access to an orderly, fair, and timely system of arbitration and resolution;

c. Documentation and reimbursement systems that are clear, that accurately estimate costs associated with services and outcomes provided, and that contain only those elements necessary to substantiate specific outcomes required; and
d. Training in Services that are provided.

7. The values of Recovery, Self Determination, Person Centered Planning and Consumer and Family driven services voiced during the State and Authority's local public input process, reflected in the North Carolina State Plan and recently affirmed by the President's New Freedom Commission Report, shall be the basis for the development of a new system of care and this Demonstration Project.

GOALS OF THE DEMONSTRATION PROJECT:

1. To provide a new funding strategy that includes single management of all resources through a public local system manager, a Local Management Entity (LME), in order to provide for coordination and blending of funding resources; collaboration with out- of-system resources; appropriate and accountable distribution of resources; and allocation of the most resources to the people with the greatest disabilities;

2. To transition the local system toward treatment with effective practices that result in real life outcomes for people with disabilities;

3. To promote community acceptance and inclusion of people with disabilities, to provide outreach to people in need of services, to promote and ensure accommodation of cultural values in services and supports, and to serve people in their local communities whenever possible;

4. To provide for easy access to the system of care;

5. To ensure quality management that focuses on health and safety, protection of rights, achievement of outcomes, accountability, and that strives to both monitor and continually improve the system of care;

6. To empower consumers and families to set their own priorities, take reasonable risks, participate in system management, and to shape the system through their choices of services and providers;

7. To empower the Local Management Entity to build local partnerships with the people who depend on the system for services and supports, with community stakeholders and with the providers of service; and

8. To demonstrate an interactive, mutually supportive, and collaborative partnership between the State Agencies and the Local Management Entity in the implementation of public policy at the local level and realization of the state's goals of system reform delineated in the Blueprint for Change.

The Piedmont Local Management Entity, as a public local system manager and implementer of the State's public policy, shall develop the infrastructure and functional capacity to direct, coordinate, manage, and ensure accountability in this transformation of the local system and to attain the goals established in this Performance Contract.

Attachment D

NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
BUSINESS ASSOCIATE ADDENDUM TO STANDARD CONTRACT

This Agreement is made effective by and between the Division of Medical Assistance ("Covered Entity") and Piedmont Area Mental Health, Developmental Disabilities and Substance Abuse Authority ("Business Associate") (collectively the "Parties").

1. BACKGROUND

a. Covered Entity and Business Associate are parties to a contract entitled RFP for **Enhanced Care Management and Related Services Pilot Project** (the "Contract"), whereby Business Associate agrees to perform certain services for or on behalf of Covered Entity.

b. Covered Entity is an organizational unit of the North Carolina Department of Health and Human Services (the "Department") that has been designated in whole or in part by the Department as a health care component for purposes of the HIPAA Privacy and Security Rules.

c. The relationship between Covered Entity and Business Associate is such that the Parties believe Business Associate is or may be a "business associate" within the meaning of the HIPAA Privacy and Security Rules.

d. The Parties enter into this Business Associate Addendum to the Contract with the intention of complying with the HIPAA Privacy and Security Rules provision that a covered entity may disclose electronic protected health information or other protected health information to a business associate, and may allow a business associate to create or receive electronic protected heath information or other protected health information on its behalf, if the covered entity obtains satisfactory assurances that the business associate will appropriately safeguard the information.

2. DEFINITIONS

Unless some other meaning is clearly indicated by the context, the following terms shall have the following meaning in this Agreement:

a. "Electronic Protected Health Information" shall have the same meaning as the term "electronic protected health information" in 45 CFR 160.103, limited to the information created or received by Business Associate from or on behalf of a Covered Entity.

b. "HIPAA" means the Administrative Simplification Provisions, Sections 261 through 264, of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

c. "Individual" shall have the same meaning as the term "individual" in 45 CFR160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).

d. "Privacy and Security Rules" shall mean the Standards for Privacy of Individually Identifiable Health Information and Security Standards for the Protection of Electronic Protected Health Information in accordance with 45 CFR part 160 and part 164, subparts A and E.

e. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

f. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR 164.103.

g. "Secretary" shall mean the Secretary of the United States Department of Health and Human Services or his designee.

h. "Security Incident" shall have the same meaning as the term "security incident" in 45 CFR 164.304.

i. Unless otherwise defined in this Agreement, terms used herein shall have the same meaning as those terms have in the Privacy and Security Rules.

3. OBLIGATIONS OF BUSINESS ASSOCIATE

a. Business Associate agrees to not use or disclose electronic protected health information or other protected health information other than as permitted or required by this Agreement or as required by law.

b. Business Associate agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information and other protected health information that it creates, receives, maintains, or transmits on behalf of a Covered Entity, as required by the Privacy and Security Rules.

c. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of electronic protected health information or other protected health information by a Business Associate in violation of the requirements of this Agreement.

d. Business Associate agrees to report to Covered Entity (i) any use or disclosure of electronic protected health information or other protected health information not provided for by this Agreement of which it becomes aware and (ii) any security incident of which it becomes aware.

e. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides electronic protected health information and/or other protected health information received from, or created or received by Business Associate on behalf of Covered Entity (i) agrees to be bound by the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information, and (ii) agrees to implement reasonable and appropriate safeguards to protect such information.

f. Business Associate agrees to provide access, at the request of a Covered Entity, to electronic protected health information and other protected health information in a Designated Record Set to a Covered Entity or, as directed by a Covered Entity, to an individual in order to meet the requirements under 45 CFR 164.524.

g. Business Associate agrees, at the request of a Covered Entity, to make any amendment(s) to electronic protected health information and other protected health information in a Designated Record Set that a Covered Entity directs or agrees to pursuant to 45 CFR 164.526.

h. Unless otherwise prohibited by law, Business Associate agrees to make internal practices, books, and records, including policies and procedures concerning electronic protected health information and other protected health information, relating to the use and disclosure of electronic protected health information and other protected health information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or to the Secretary, in a time and manner designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy and Security Rules.

i. Business Associate agrees to document such disclosures of electronic protected health information and other protected health information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of electronic protected health information and other protected health information in accordance with 45 CFR 164.528, and to provide this information to Covered Entity or an individual to permit such a response.

4. PERMITTED USES AND DISCLOSURES

a. Except as otherwise limited in this Agreement or by other applicable law or agreement, if the Contract permits, Business Associate may use or disclose electronic protected health information and other protected health information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract, provided that such use or disclosure:

   1) would not violate the Privacy and Security Rules if done by Covered Entity; or

   2) would not violate the minimum necessary policies and procedures of the Covered Entity.

b. Except as otherwise limited in this Agreement or by other applicable law or agreements, if the Contract permits, Business Associate may use electronic protected health information and other

protected health information as necessary for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

c. Except as otherwise limited in this Agreement or by other applicable law or agreements, if the Contract permits, Business Associate may disclose electronic protected health information and other protected health information for the proper management and administration of the Business Associate, provided that:

   1) disclosures are required by law; or

   2) Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and will be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

d. Except as otherwise limited in this Agreement or by other applicable law or agreements, if the Contract permits, Business Associate may use electronic protected health information and other protected health information to provide data aggregation services to Covered Entity as permitted by 45 CFR 164.504(e)(2)(i)(B).

e. Notwithstanding the foregoing provisions, Business Associate may not use or disclose electronic protected health information or other protected health information if the use or disclosure would violate any term of the Contract or other applicable law or agreements.

5. TERM AND TERMINATION

a. **Term**. This Agreement shall be effective as of the effective date stated above and shall terminate when the Contract terminates.

b. **Termination for Cause**. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity may, at its option:

   1) Provide an opportunity for Business Associate to cure the breach or end the violation, and terminate this Agreement and services provided by Business Associate, to the extent permissible by law, if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;

   2) Immediately terminate this Agreement and services provided by Business Associate, to the extent permissible by law; or

   3) If neither termination nor cure is feasible, report the violation to the Secretary as provided in the Privacy and Security Rules.

c. **Effect of Termination**.

   1) Except as provided in paragraph (2) of this section or in the Contract or by other applicable law or agreements, upon termination of this Agreement and services provided by Business Associate, for any reason, Business Associate shall return or destroy all electronic protected health information and other protected health information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to electronic protected health information and other protected health information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the electronic protected health information or other protected health information..

   2) In the event that Business Associate determines that returning or destroying the electronic protected health information or other protected health information is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction not feasible. Business Associate shall extend the protections of this Agreement to such electronic protected health information and other protected health information and limit further uses and disclosures of such electronic protected health information and other protected health information for those purposes that make the return or destruction infeasible, for so long

as Business Associate maintains such electronic protected health information and other protected health information.

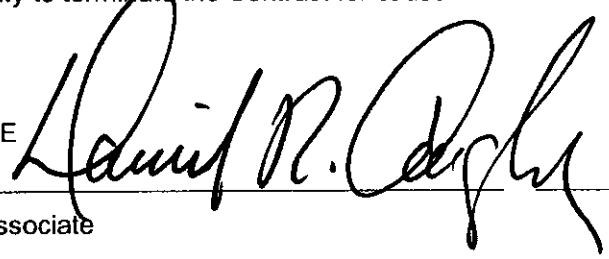
6. GENERAL TERMS AND CONDITIONS

a. This Agreement amends and is part of the Contract.

b. Except as provided in this Agreement, all terms and conditions of the Contract shall remain in force and shall apply to this Agreement as if set forth fully herein.

c. In the event of a conflict in terms between this Agreement and the Contract, the interpretation that is in accordance with the Privacy and Security Rules shall prevail. In the event that a conflict then remains, the Contract terms shall prevail so long as they are in accordance with the Privacy and Security Rules.

d. A breach of this Agreement by Business Associate shall be considered sufficient basis for Covered Entity to terminate the Contract for cause.

SIGNATURE  7/25/05

Business Associate Date

Attachment E

Department of Health and Human Services
Division of Medical Assistance

Certification Regarding Environmental Tobacco Smoke
Certification for Contracts, Grants, Loans and Cooperative Agreements

Public Law 103-227, Part C-Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000.00 per day and/or the imposition of an administrative compliance order on the responsible entity.

By signing and submitting this application, the Contractor certifies that it will comply with the requirements of the Act. The Contractor further agrees that it will require the language of this certification be included in any subawards that contain provisions for children's services and that all subgrantees shall certify accordingly.

Signature	Title: Area Director/CEO
Piedmont Behavioral Healthcare	Date: 7/25/05
Agency/Organization	

(Certification signature shall be same as Contract signature.)

Attachment F

Department of Health and Human Services
Division of Medical Assistance

Certification Regarding Lobbying

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federally funded contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form SF-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

3. The undersigned shall require that the language of this certification be included in the award document for subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) who receive federal funds of $100,000.00 or more and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000.00 and not more than $100,000.00 for each such failure.

Signature	Title: Area Director/CEO
Agency/Organization: Piedmont Behavioral Healthcare	Date: 7/25/05

(Certification signature shall be the same as Contract signature.)

Attachment F

Department of Health and Human Services
Division of Medical Assistance

Certification Regarding Lobbying

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federally funded contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form SF-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

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This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000.00 and not more than $100,000.00 for each such failure.

Signature

Area Director/CEO
Title

Piedmont Behavioral Healthcare
Agency/Organization

7/25/05
Date

(Certification signature shall be the same as Contract signature.)

Attachment F Continued

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
☐ a. contract ☐ b. grant ☐ c. cooperative agreement ☐ d. loan ☐ e. loan guarantee ☐ f. loan insurance	☐ a. Bid/offer/application ☐ b. initial award ☐ c. post-award	☐ a. initial filing ☐ b. material change **For Material Change Only:** year-quarter _____ date of last report _____

4. Name and Address of Reporting Entity: ☐ Prime ☐ Subawardee Tier _____, *if known*: Congressional District, *if known*	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, *if known*
6. Federal Department/Agency:	7. Federal Program Name/Description: CFDA Number, *if applicable*: _____
8. Federal Action Number, *if known*:	9. Award Amount, *if known*: $
10. a. Name and Address of Lobbying Entity (*if individual, last name, first name, MI*):	b. Individuals Performing Services (*including address if different from No. 10a.*) (*last name, first name, MI*):
(*attach Continuation Sheet(s) SF-LLL-A, if necessary*)	
11. Amount of Payment (*check all that apply*): $ _____ ☐ actual ☐ planned	13. Type of Payment (*check all that apply*): ☐ a. retainer ☐ b. one-time fee ☐ c. commission ☐ d. contingent fee ☐ e. deferred ☐ f. other; specify: _____
12. Form of Payment (*check all that apply*): ☐ a. cash ☐ b. In-kind; specify: nature _____ value _____	
14. Brief Description of Services Performed or to be Performed and Date(s) of Services, including officer(s), employee(s), or Member(s) contacted, for Payment Indicated in Item 11: (*attach Continuation Sheet(s) SF-LLL-A, if necessary*)	
15. Continuation Sheet(s) SF-LLL-A attached: ☐ Yes ☐ No	

16. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U. S. C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: _____ Print Name: _____ Title: _____ Telephone No: _____ Date: _____

Federal Use Only	Authorized for Local Reproduction Standard Form--SF-LLL

Attachment G

Department of Health and Human Services
Division of Medical Assistance

Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transactions

(Note: The phrase "prospective lower tier participant," means providers under contract with the Division.)

1. By signing and submitting this document, the **prospective lower tier participant** is providing the certification set out below.

2. The certification in this clause is a material representation of the fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originate may pursue available remedies, including suspension and/or debarment.

3. The prospective lower tier participant will provide immediate written notice to the person to whom this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

4. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549, 45 CFR Part 76. You may contact the person to whom this proposal is submitted for assistance in obtaining a copy of those regulations.

5. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter any lower tier covered transaction with a person who is debarred, suspended, determined ineligible or voluntarily excluded from participation in this covered transaction unless authorized by the department or agency with which this transaction originated.

6. The prospective lower tier participant further agrees by submitting this document that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that is not debarred, suspended, ineligible, or voluntarily excluded from covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List.

8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

9. Except for transactions authorized in paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension, and/or debarment.

(continued.....)

Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transactions

(1) The prospective lower tier participant certifies, by submission of this document, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, nor voluntarily excluded from participation in this transaction by any Federal department or agency.

(2) Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

Signature _____ Title _____ 7/25/05

Agency/Organization Piedmont Behavioral Healthcare Date 7/25/05

(Certification signature shall be same as Contract signature.)

Attachment H

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

Department of Health and Human Services
Division of Medical Assistance

I. By execution of this Agreement the Contractor certifies that it will provide a drug-free workplace by:

A. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

B. Establishing a drug-free awareness program to inform employees about:

(1) The dangers of drug abuse in the workplace;

(2) The Contractor's policy of maintaining a drug-free workplace;

(3) Any available drug counseling, rehabilitation, and employee assistance programs; and

(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

C. Making it a requirement that each employee be engaged in the performance of the agreement be given a copy of the statement required by paragraph (a);

D. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the agreement, the employee will:

(1) Abide by the terms of the statement; and

(2) Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction;

E. Notifying the Department within ten days after receiving notice under subparagraph (d)(2) from an employee or otherwise receiving actual notice of such conviction;

F. Taking one of the following actions, within 30 days of receiving notice under subparagraph (d)(2), with respect to any employee who is so convicted:

(1) Taking appropriate personnel action against such an employee, up to and including termination; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency; and

Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

II. The site(s) for the performance of work done in connection with the specific agreement are listed below:

1. 245 LePhillip Court, NE
(Street address)

Concord, NC 28025
(City, county, state, zip code)

2. 528 Lake Concord Road
(Street address)

Concord, NC 28025
(City, county, state, zip code)

Contractor will inform the Department of any additional sites for performance of work under this agreement.

False certification or violation of the certification may be grounds for suspension of payment, suspension or termination of grants, or government-wide Federal suspension or debarment, 45 C.F.R. 82-510.

Area Director/CEO
~~Signature~~ Title

Piedmont Behavioral Healthcare
Agency/Organization

~~Title~~ Signature

7/25/05
Date

(Certification signature should be same as Contract signature.)

Attachment I

Excerpts from NC General Statutes, Chapter 58

Chapter 58. **Insurance.**

§ 58-38-1. Title.

This Article is known and may be cited as the "Readable Insurance Policies Act." (I 979, c. 755, s. 1.)

§ 58-38-5. Purpose.

The purpose of this Article is to provide that insurance policies and contracts be readable by a person of average intelligence, experience, and education. All insurers are required by this Article to use policy and contract forms and, where applicable, benefit booklets that are written in simple and commonly used language, that are logically and clearly arranged, and that are printed in a legible format. (1979, c. 755, s. 1.) ARTICLE 38.

§ 58-67-65. Prohibited practices.

(a) No health maintenance organization, or representative thereof - may cause or knowingly permit the use of advertising, which is untrue or misleading, solicitation, which is untrue or misleading, or any form of evidence of coverage, which is deceptive. For purposes of this Article:

(1) A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect, which is or may be significant to an enrollee of, or person considering enrollment in, a health care plan.

(2) A statement or item of information shall be deemed to be misleading, whether or not it may be literally untrue, if, in the total context in which such statement is made or such item of information is communicated, such statement or item of information may be reasonably understood by a reasonable person, not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage or the absence of any exclusion, limitation, or disadvantage of possible significance to an enrollee of. or person considering enrollment in a health care plan, if such benefit or advantage or absence of limitation, exclusion or disadvantage does not in fact exist.

(3) An evidence of coverage shall be deemed to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography and format, as well as language, shall be such as to cause a reasonable person, not possessing special knowledge regarding health care plans and evidences of coverage therefore, to expect benefits, services, premiums, or other advantages which the evidence of coverage does not provide or which the health care plan issuing such evidence of coverage does not regularly make available for enrollees covered under such evidence of coverage.

Attachment J

Definition of Terms

1 **Action** - The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the State; the failure of the LME to act within the timeframes provided in 42 C.F.R. 438.408(b). For a rural area resident with only one LME, the denial of a Medicaid enrollee's request to obtain services outside the network:

- From any other provider in terms of training, experience, and specialization) not available in the Network
- From a provider not part of the network who is the main source of a service to the recipient—provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the Network or does not meet the qualifications, the enrollee is given a choice of participating providers and is transitioned to a participating provider within 60 days.
- Because the only plan or provider available does not provide the service because of moral or religious objections.
- Because the enrollee's provider determines that the recipient needs related services that would subject the recipient to unnecessary risk if received separately and not all related services are available within the network.

2 **Adjudicate** – a determination to pay or reject a claim.

3 **ANSI** – American National Standards Institute

4 **Appeal** - a request for review of an action, as "action" is defined in this Attachment R in 1.1 above.

5 **Attending Physician** - The participating or referral physician in whose immediate care an Enrollee may be for a particular illness, injury or condition.

6 **Best Practices**—Recommended practices, including Evidence Based Practices that consist of those clinical and administrative practices that have been proven to consistently produce specific, intended results.

7 **Capitation Payment** - The amount to be advanced monthly to the LME for each Potential Enrollee covered by the LME's Benefit Plan based on Eligibility Category, age, whether or not the Potential Enrollee receives services during the period covered by the payment.

8 **Care Management** - Care Management is non-face-to face monitoring of an individual consumer's care and services, including follow-up activities, as well as assistance to consumers in accessing care and non-plan services, including referrals to providers and other community agencies.

9 **Catchment Area** – Geographic Service Area meaning a defined grouping of counties.

10 **Case Management** - Services providing assistance in gaining access to and coordination of needed rehabilitation, habilitation, medical, social, educational, and other medically necessary services. Activities include: 1) assessment of the eligible individual to determine service needs 2) development of a specific care plan, 3) referral and related activities to help the individual obtain needed services, 4) monitoring and follow-up. Case management services are referred to as targeted case

management (TCM) services when the services are not furnished in accordance with Medicaid statewideness or comparability requirements, allowing states to target case management to specific classes of individuals and/or to individuals who reside in specified area.

11 **C.F.R.** – Code of Federal Regulations

12 **Clean Claim** –A "Clean claim" is a claim that can be processed without obtaining additional information from the provider of the services or from a third party. It does not include a claim under review for medical necessity, or a claim that is from a Provider that is under investigation by a governmental agency for fraud or abuse.

13 **CMS** - Centers for Medicare and Medicaid Services

14 **Complaint**– A dispute or objection by or on behalf on an Enrollee regarding a provider, or the coverage, operations, or management policies of the LME which does not meet the definition of a Grievance or Appeal of an Action as defined in this Contract.

15 **Concurrent Review**- A review conducted by the LME during a course of treatment to determine whether services meet Medical Necessity and quality standards and whether services should continue as prescribed or should be terminated, changed or altered.

16 **Contract Term** - The initial term of this Contract or any renewal term.

17 **Covered Services** - The services identified in Attachment L which the LME agrees to provide or arranges to provide to all Enrollees pursuant to the terms of this Contract.

18 **Cultural Competency** - The understanding of the social, linguistic, ethnic, and behavioral characteristics of a community or population and the ability to translate systematically that knowledge into practices in the delivery of behavioral health services. Such understanding may be reflected, for example, in the ability to: identify and value differences; acknowledge the interactive dynamics of cultural differences; continuously expand cultural knowledge and resources with regard to populations served; collaborate with the community regarding service provisions and delivery; and commit to cross-cultural training of staff and develop policies to provide relevant, effective programs for the diversity of people served.

19 **DHHS** - United States Department of Health and Human Services

20 **Days** - Except as otherwise noted, refers to calendar days. "Working day" or "business day" means day on which DMA is officially open to conduct its affairs.

21 **Day of Enrollment** – The first day of the month.

22 **Denial of Services** – A determination made by the LME in response to a Provider's request for approval to provide in-plan services of a specific duration and scope which:

- disapproves the request completely; or
- approves provision of the requested service(s), but for a lesser scope or duration than requested by the provider; (an approval of a requested services which includes a requirement for a concurrent review by the LME during the authorized period does not constitute a denial); or
- disapproves provision of the requested service(s), but approves provision of an alternative service(s)

23 **Department** – North Carolina Department of Health and Human Services

24 **Disenrollment** - Action taken by DMA to remove an Enrollee's name from the monthly Enrollment Report following DMA's determination that the Enrollee is no longer eligible for enrollment in the LME.

25 **DMA**- Division of Medical Assistance

26 **DMH/DD/SAS** –Division of Mental Health, Developmental Disabilities and Substance Abuse Services

27 **DSS** - Department of Social Services

28 **Emergency Medical Condition –** A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(1) Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
(2) Serious impairment to bodily functions, or
(3) Serious dysfunction of any bodily organ or part.

29 **Emergency Services** - with respect to an Enrollee covered inpatient and outpatient services that:

(A) Are furnished by a provider that is qualified to furnish such services; and,
(B) Are needed to evaluate or stabilize an emergency medical condition as defined above.

30 **Emergent Need - Mental Health** - A life threatening condition in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions that may result in harm to self or harm to others, and/or displaying vegetative signs and is unable to care for self.

31 **Emergent Need - Substance Abuse** – A life threatening condition in which the person is by virtue of their use of alcohol or other drugs, suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions which may result in self-harm or harm to others, and/or is unable to adequately care for self without supervision due to the effects of chronic substance abuse or dependence.

32 **Encounter Data** - A record of a Covered Service rendered by a provider to an Enrollee who is enrolled in the LME during the date of service. It includes all services for which the LME incurred any financial responsibility; in addition, it may include claims for reimbursement, which were denied by the LME.

33 **Enrollment** - Action taken by the DMA to add a Medicaid recipient's name to the monthly Enrollment Report following the receipt and approval by DMA of Medicaid Eligibility for a person living in the defined catchment area.

34 **Enrollees** – The Medicaid recipient that is currently enrolled in the LME's PIHP.

35 **Enrollment Period** - The time span during which a recipient is enrolled with a LME.

36 **Expanded Services** - Services included in Covered Services, which are in addition to the minimum coverage required by DMA and which the LME agrees to provide throughout the term of this Contract in accordance with the standards and requirements set forth in this Contract.

37 **Facility** - Any premises (a) owned, leased, used or operated directly or indirectly by or for the LME for purposes related to this Contract; or (b) maintained by a sub-contractor to provide services on behalf of the LME as part of this Contract.

38 **Fee-for-Service** - A method of making payment directly to health care providers enrolled in the Medicaid program for the provision of health care services to Recipients based on the payment methods set forth in the State Plan and the applicable policies and procedures of DMA.

39 **Fiscal Agent** - An agency that processes and audits Medicaid provider claims for payment and performs certain other related functions as an agent of DMA.

40 **FQHC** - Federally Qualified Health Center

41 **FTE** - the acronym for "Full Time Equivalent"; a unit of employee work time equal to forty (40) work hours per week.

42 **Grievance** - an expression of dissatisfaction by or on behalf of an Enrollee about any matter other than an action, as "action" is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the LME level and access to the State fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights).

43 **Grievance Procedure** - The written procedures pursuant to which Enrollees may express dissatisfaction with the provision of services by the LME and the methods for resolution of Enrollee complaints by the LME

44 **Health Assessment** - The systematic collection of subjective and objective information used to determine the client's health status and need for medical care in relation to developmental, physiological, preventive, and psychological life processes.

45 **Hearing** - A formal proceeding before an Office of Administrative Hearing Law Judge in which parties affected by an action or an intended action of DMA shall be allowed to present testimony, documentary evidence and argument as to why such action should or should not be taken.

46 **Health Plan Employer Data and Information Set (HEDIS)** is a set of standardized performance measures designed to reliably compare the performance of managed health care plans.

47 **IDEA - Individuals with Disabilities Education Act (IDEA)** - Federal law (PL 99-457) which requires special services for children with special needs from birth to age twenty one (21) years.

48 **Innovations Waiver** – The 1915(c) Home and Community Based Services Waiver that operates in the five-county area covered by this Contract. The Innovations Waiver replaces the Community Alternatives Program for Persons with Mental Retardation and Developmental Disabilities (CAP-MR/DD) in the Piedmont counties.

49 **In-Plan Services** – services which are included in the behavioral health capitation rate and are the payment responsibility of the LME.

50 **Insolvency** - The inability of the LME to pay its obligations when they are due.

51 **LME** – Local Management Entity, a local political subdivision of the state of North Carolina as established under General Statute 122C.

52 **Medicaid Identification (MID) Card** - The Medical Assistance Eligibility Certification card issued monthly by DMA to Recipients.

53 **Medicaid for Infants and Children (MIC)** - A program for medical assistance for children under the age of nineteen (19) whose countable income falls under a specific percentage of the Federal Poverty Limit and who are not already eligible for Medicaid in another category.

54 **Medicaid for Pregnant Women (MPW)** - A program for medical assistance for pregnant women whose income falls under a specified percentage of the Federal Poverty Limit and who are not already eligible in another category.

55 **Medical Assistance (Medicaid) Program** - DMA's program to provide medical assistance to eligible citizens of the State of North Carolina, established pursuant to Chapter 58, Articles 67 and 68 of the North Carolina General Statutes and Title XIX of the Social Security Act, 42 U.S.C. 1396 et. seq.

56 **Medical Record** - A single complete record, maintained by the Provider of services, which documents all of the treatment, plans developed for, and behavioral health services received by, the Enrollee.

57 **Medically Necessary Treatment** – Medically necessary treatment shall be defined as those procedures, products and services that are provided to Medicaid recipients (excluding Qualified Medicare Beneficiaries) that are:

- Necessary and appropriate for the prevention, diagnosis, palliative, curative, or restorative treatment of a mental health or substance abuse condition;
- Consistent with Medicaid policies and National or evidence based standards, North Carolina Department of Health and Human Services defined standards, or verified by independent clinical experts at the time the procedures, products and the services are provided;
- Provided in the most cost effective, least restrictive environment that is consistent with clinical standards of care;
- Not provided solely for the convenience of the recipient, recipient's family, custodian or provider;
- Not for experimental, investigational, unproven or solely cosmetic purposes;
- Furnished by or under the supervision of a practitioner licensed (as relevant) under State law in the specialty for which they are providing service and in accordance with Title 42 of the Code of Federal Regulations, the Medicaid State Plan, the North Carolina Administrative Code, Medicaid medical coverage policies, and other applicable Federal and state directives;
- Sufficient in amount, duration and scope to reasonably achieve their purpose, and
- Reasonably related to the diagnosis for which they are prescribed regarding type, intensity, duration of service and setting of treatment.

Within the scope of the above guidelines, medically necessary treatment shall be designed to:

- Be provided in accordance with a person centered service plan which is based upon a comprehensive assessment, and developed in partnership with the individual (or in the case of a child, the child and the child's family or legal guardian) and the community team;
- Conform with any advanced medical directive the individual has prepared;
- Respond to the unique needs of linguistic and cultural minorities and furnished in a culturally relevant manner; and
- Prevent the need for involuntary treatment or institutionalization.

58 **Network Provider** – A provider of behavioral health services that meets the LME's criteria for enrollment, credentialing and/or accreditation requirements and is under written agreement to provide services.

59 **NSF** - National Standard Format

60 **Out-of-Area Services** – In-plan behavioral health services provided to an Enrollee while the Enrollee is outside the catchment area.

61 **Out-of-Plan Services** - Health care services, which the LME is not required to provide under the terms of this Contract. The services are Medicaid covered services reimbursed on a fee-for-service basis.

62 **Out-of-Network Provider** - Any person or entity providing services who does not have a written provider agreement with the LME and is therefore not included or identified as being in the LME's Provider Network.

63 **PIHP** – Prepaid inpatient health plan. An entity that provides medical services to Enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates; provides arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its Enrollees; and does not have a comprehensive risk contract.

64 **Potential enrollee** – A Medicaid recipient who is subject to mandatory enrollment.

65 **Primary Care Provider** (PCP) - A licensed medical practitioner responsible for supervising, coordinating and providing initial and primary care to a Member, for initiating referrals for specialist care, and for maintaining the continuity of patient care; a General Medical Practitioner, an Internist, a Pediatrician, an Obstetrician/Gynecologist, a Family Practitioner, a Physician's Assistant, or a Family Nurse Practitioner. For children with special health care needs, a specialist may perform as a Primary Care Physician.

66 **Prior Authorization** - The act of authorizing specific services before they are rendered.

67 **Provider** - Any person or entity providing behavioral health services.

68 **Provider Network** – the agencies, professional groups, or professionals under contract to the LME, that meet LME standards and that provide authorized Covered Services to eligible and enrolled persons.

69 **QAPI (Quality Assurance Performance Improvement) -** Also referred to as a health care quality improvement system for states; a framework for a health care quality improvement system for Medicaid managed care; recommends evaluation procedures to be used by states to evaluate a Plan's internal quality improvement system.

70 **Qualified Professional -** Any individual with appropriate training or experience as specified by the North Carolina General Statutes or by rule of the North Carolina Commission on Mental Health, Developmental Disabilities and Substance Abuse Services in the fields of mental health or developmental disabilities or substance abuse treatment or habilitation, including physicians, psychologists, psychological associates, educators, social workers, registered nurses, certified fee-based practicing pastoral counselors, and certified counselors. (NC General Statute 122C-3)

71 **Quality Assurance/Quality Improvement** - The process of assuring that health care services provided to Enrollees are appropriate, timely, accessible, available and medically necessary.

72 **Recipient** – An Enrollee who is receiving services.

73 **Reconsideration Review** – An informal session before a DMA Hearing Officer and Medical Policy Director wherein an Enrollee, affected by an action or an intended action by the LME, shall be allowed to present and discuss information as to why such action should or should not be taken, and described more specifically in NCAC T10: 22H (for Enrollees) and NCAC T10: 22J (for the LME). The decision of the Hearing Officer is subject to appeal through the Office of Administrative Hearings (OAH).

74 **Reinsurance** - Insurance purchased by a Plan from insurance companies to protect against part of the costs of providing Covered Services to Members.

75 **Risk Contract** - A contract under which the contractor: 1) assumes risk for the cost of the services covered under the contract; and 2) incurs loss if the cost of furnishing the services exceeds the payments under the contract. A significant chance of loss assumed by the LME which arises if cost of providing Covered Services to Enrollees exceeds the capitation rate paid by DMA to the LME.

76 **Routine Need - Mental Health** - A condition in which the person describes signs and symptoms which are resulting in impairment and functioning of life tasks; impact the person's ability to participate in daily living; and/or have markedly decreased the person's quality of life.

77 **Routine Need – Substance Abuse** - A condition in which the person describes signs and symptoms consequent to substance use resulting in a level of impairment which can likely be diagnosed as a substance use disorder according to the current version of the Diagnostic and Statistical Manual.

78 **Service Location** - Any location at which an Enrollee obtains any Covered Services from a LME Provider.

79 **Service Management Record** - A record of Enrollee demographics, authorizations, referrals, actions and services billed by Network Providers.

80 **State** - State of North Carolina

81 **State Plan** - The "State Plan" submitted under Title XIX of the Social Security Act, Medical Assistance Program for the State of North Carolina and approved by CMS.

82 **Subcontract** - An agreement approved in writing by DMA, which is entered into by the LME in accordance with Section 12.

83 **Subcontractor** - Any person or entity which has entered into a subcontract with the LME

84 **Third Party Resource** - Any resource available to a Member for payment of expenses associated with the provision of Covered Services, other than those which are exempt under Title XIX of the Act, including but not limited to, insurers, tort-feasors, and worker's compensation plans.

85 **Urgent Need - Mental Health** – A condition in which a person is not actively suicidal or homicidal; denies having a plan, means or intent for suicide or homicide but expresses feelings of hopelessness, helplessness or rage; has potential to become actively suicidal or homicidal without immediate intervention; displays a condition which could rapidly deteriorate without immediate intervention; and/or without diversion and intervention will progress to the need for emergent services and care.

86 **Urgent Need - Substance Abuse** – A condition in which the person is not imminently at risk of harm to self or others or unable to adequately care for self, but by virtue of their substance use is in need of prompt assistance to avoid further deterioration in the person's condition which could require emergency assistance.

87 **Utilization Management** – The process of evaluating the necessity, appropriateness, and efficiency of behavioral health care services against established guidelines and criteria.

88 **WFFA** - Work First for Family Assistance

ATTACHMENT K

ELIGIBILITY CATEGORIES

1931 Children and Related Poverty Level Populations (TANF)*
1931 Adults and Related Poverty Level Populations (TANF)
Foster Care Children (HSF, IAS - Eligible at discretion of Department of Social Services and guardian)*
Blind/Disabled Children and Related Populations*
Blind/Disabled Adults and Related Populations
ICF-MR*
Aged and Related Populations
SSI Recipients*
Dual Eligibles (Medicaid and Medicare beneficiaries)
Residents of Adult Care Homes (SAD, SAA)
Participants in Community Alternatives Programs (CAP/DA, CAP/AIDS, CAP/C)*
Optional categorically and medically needy families and children (MAF) who are not in deductible status*
Medicaid for infants and children (MIC)*
Medicaid for Pregnant Women (MPW)

*Children under the age of three years are not eligible for any services covered under this contract EXCEPT for the HCBS Innovations Waiver services.

Rate Cells for Capitated Payments:

1. AFDC – Adults and children over age 3
2. Foster Children—Over age 3
3. Aged – Ages 65 and above
4. Blind/Disabled – Ages 3-20
5. Blind/Disabled – Ages 21+
6. HCBS Innovations Waiver Participants - All Ages

- **Inpatient Hospital**
- **Outpatient Rehabilitation Option services including outpatient individual and group services**
- Clinic Option MH and SA services
- **Targeted Case Management**
- **Day Treatment and Partial Hospitalization for Adults and Children**
- **Psychosocial Rehabilitation**
- **Assertive Community Treatment Team (ACTT)**
- **Facility-Based Crisis Service**
- **Community-Based Services**
- **Residential Services, Level I**
- **Residential Services, Level II**
- **Residential Services Level III**
- **Residential Services Level IV**
- **PRTF Non IMD, No room and Board, under 21**
- **Intermediate Care Facility Services for Persons with Mental Retardation (ICF-MR)**

***HCBS waiver services in the "Innovations" waiver will also be included as in-plan benefits. These services are**

- **Personal Assistance Services**
- **Crisis Services**
- **Residential Supports**
- **Day Supports**
- **Personal Care Services**
- **Supported Employment**
- **Home and Community Supports**
- **Respite Services**
- **Supports Brokerage Services/Functions**
- **Financial Management Services Services/Functions**
- **Augmentative Communication Devices**
- **Caregiver Training and Education**
- **Community Transition Supports**
- **Home Modifications**
- **Individual Directed Goods and Services**
- **Individual Training and Education Services**
- **Specialized Consultative Services**
- **Specialized Equipment and Supplies**
  Vehicle Adaptations

ATTACHMENT M

SCOPE OF EPSDT SERVICES

Section 1905(r)(5) of the Social Security Act sets forth the basic requirements for the EPSDT program. The Act requires that any service that is covered under 1905(a) of the Social Security Act which is medically necessary to treat or ameliorate a defect, physical illness, or condition identified through screening must be provided to EPSDT participants. Services under EPSDT must be sufficient in amount, duration, or scope to reasonably achieve their purpose. The amount, duration and scope of EPSDT services may not be denied arbitrarily or reduced solely because of the diagnosis, type of illness, or condition. Appropriate limits may be placed on EPSDT services based on medical necessity.

Treatment for MH/SA Conditions identified in EPSDT screenings will be furnished through the Piedmont PIHP. Agencies conducting the screenings will coordinate with service providers.

Attachment N

Statistical Reporting Measures

With further direction and instructions from DMA, the LME will be required to submit data and measurements on an annual (unless otherwise indicated) basis for quality of care and service measures and performance improvement projects as defined in Attachment O for Medicaid members. Other quality measures may be phased in during consecutive contract years at the discretion of DMA. The LME will be provided guidance from the NC DMA in meeting the statistical and other reporting requirements of this contract.

Described below are the reports that each LME is required to complete and send to NC DMA by June 30 of each calendar year. The period of time reported upon will be January 1 through December 31 of the preceding calendar year. The LME will utilize the HEDIS Technical Specifications, as applicable, for the particular reporting year to fulfill the statistical reporting requirements or will seek and receive written approval from DMA before April 1st of the calendar year for any revisions or amendments to the HEDIS specifications. The LME will use technical specifications provided by the NC DMA for all measures without pertinent HEDIS specifications. The LME will execute all applicable HEDIS Technical Specifications as they pertain to the Medicaid population of the LME. An explanation of how the data was calculated is also required in the yearly report. Questions regarding reporting requirements may be addressed through quarterly PIHP Quality Management or Data Advisory Committee meetings. For the purpose of clarification, when "member" is written, the reference is to all or specified Medicaid enrollees.

By June 30, 2006, the Plan will report measures based on the first nine months of LME operations for the number of months for which capitated Medicaid payments are paid (proposed as April 1, 2005 through December 31, 2005). The annual measures required for reporting by July 31, 2005 are designated by a (+) and shall encompass data from the second quarter, April 2005 through June 2005. The Complaints/Grievances/Appeals measure shall be reported initially in the requested timeframe after the first calendar quarter of Plan operations. All measures in this appendix will be required for reporting by June 30, 2006 and for the remaining years of the contract.

EFFECTIVENESS OF CARE MEASURES:

1. Follow-up After Hospitalization for Mental Illness (*) **The percentage of discharges for Medicaid enrollees, 6 years of age and older, who were hospitalized for treatment of selected mental health disorders, who were continuously enrolled for 30 days after discharge (without gaps) and who were seen on an ambulatory basis or who were in day/night treatment with a mental health provider.**
2. **Readmission Rates for Mental Health (*)** The number and proportion of Medicaid enrollees readmitted to inpatient psychiatric hospital care within 30 calendar days.
3. **Readmission Rates for Substance Abuse** The number and proportion of Medicaid enrollees readmitted to substance abuse treatment facilities within 30 calendar days.
4. **Ambulatory Follow-Up within 7 calendar days of discharge for Substance Abuse therapy** - The number and proportion of adult enrollees, age 21 and over with Substance Abuse diagnoses who have a visit within 7 days of discharge from a Substance Abuse facility.
5. **Ambulatory Follow-Up within 7 calendar days of discharge for Mental Health(*)**The number and proportion of Medicaid enrollees with a mental health diagnosis, excluding Substance Abuse, that had an ambulatory follow-up visit within 7 calendar days from discharge from inpatient psychiatric hospital care . This measure will be subset into adults, age 21 and over, and children, under age 21.
6. **Number of Consumers Moved from Institutional Care to Community Care (*)**The number of Medicaid enrollees discharged from Institutional Care in an ICF-MR into the community through use of 1915(c) waiver funding.

ACCESS/AVAILABILITY

1. **Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**-The percentage of adults diagnosed with AOD dependence who initiate treatment through one of the following: an inpatient AOD admission or an outpatient service for AOD abuse or dependence and any additional AOD services within 14 days.
2. Call Answer Timeliness (+) **Assesses the percentage of calls received by the member services call centers (during the member services operating hours) during the measurement year that were answered by a live voice within 30 seconds.**
3. Call Abandonment (+) **Assesses the percentage of calls received by the member services call center (during operating hours) during the measurement year that were abandoned by the caller before being answered by a live voice.**
4. **Service Availability/Accessibility (+)** Assesses Medicaid enrollee accessibility to needed routine, urgent and emergent care within the requirements of the LME. Report the number and type of calls received and the disposition of the calls.
5. **Payment Denials (*) (+)** - Number and percentage of visits for services (ER, consulting specialists, ancillary) obtained but not authorized by the LME.
6. **Number and Percentage of Total Services that are rendered out of network (+)**
7. **Timeliness of Initial Service Delivery (*)** The average amount of time from CAP-MR/DD "C" waiver services level of care determination to approval for initiation of services, the average amount of time from approval for initiation of services to plan of service development, and the average amount of time from plan of service development to implementation of direct care services.

PATIENT AND PROVIDER SATISFACTION

1. **Provider Satisfaction Survey(*)** A subjective measure of providers participating in the program with regard to satisfaction with program areas such as claims submission and payment, assistance from the LME, communication, etc. This survey would be developed by the LME and approved by DMA prior to use.
2. **Complaints/Grievances/Appeals (*) (+)** Report separately all Medicaid enrollee complaints, grievances, and appeals including the total number of enrollees served, total number of both complaints and grievances categorized by reason, reported separately; the number of both complaints and grievances referred to second level review or appeal, reported separately; and the number of complaints and grievances resolved at each level, total time of resolution and outcome, reported separately. Reports are due no later than 45 calendar days after the end of each calendar quarter.
3. **ECHO Patient Satisfaction Survey or Other Comparable Patient Satisfaction Survey approved by DMA prior to use (*)** Report results per ECHO or other approved survey specifications for adults and children. This measure is designed to report Medicaid enrollee satisfaction with LME performance regarding access to and quality of services rendered through the LME.

USE OF SERVICES

1. **Mental Health Utilization (*) Inpatient Discharges and Average Length of Stay**-Summarizes the utilization of inpatient mental health services, stratified by age and sex.
2. **Mental Health Utilization (*) Percentage of Members Receiving Inpatient, Day/ Night Care, Ambulatory and Other Support Services-**Reports the number and percentage of Medicaid enrollees receiving mental health services during the measurement year in the above categories, giving an overview of the extent to which the organization uses the different levels of mental health care. In addition to rates of utilization, report which services are included in each category.
3. **Chemical Dependency Utilization – Inpatient Discharges and Average Length of Stay-** Summarizes the utilization of inpatient chemical dependency services, stratified by age and sex.

4. **Chemical Dependency Utilization – Percentage of Members receiving Inpatient, Day/ Night Care, Ambulatory and Support Services** Reports the number and percentage of Medicaid enrollees receiving chemical dependency services during the measurement year in the above

categories, giving an overview of the extent to which the organization uses the different levels of chemical dependency care. In addition to rates of utilization, report which services are included in each category.

5. **Identification of Alcohol and Other Drug Services** Reports the number and percentage of members with an alcohol and other drug (AOD) claim. AOD claims contain a diagnosis of AOD abuse or dependence and a specific AOD-related service during the measurement year.

6. **Utilization Management of the Provision of High Use Services (*)** The number and percentage of enrollees receiving Personal Care Services, Habilitation Services, and Respite Services, and the average amount of Personal Care Services, Habilitative Services and Respite Services used per enrollee receiving services.

HEALTH PLAN STABILITY

Network Capacity (+) (*) **The number and type of all providers in the network by the type of service rendered**

PLAN DESCRIPTIVE INFORMATION

Unduplicated Count of Medicaid Members(*)(+) **Provides the age, sex, Medicaid eligibility category and of enrollee served and enrolled by the LME and the average number of months Medicaid members are served by the LME and enrolled in the LME.**
Diversity of Medicaid Membership **(*)(+)-Assesses the number and percentage of Medicaid members served versus enrolled at any time during the measurement year by race/ ethnicity, Hispanic origin and spoken language. This measure is required only if the LME has received the necessary information from DMA to calculate the measure by May 1st of each calendar reporting year.**

HEALTH AND SAFETY

Critical Incident Reports (*) (+) The number and percentage of Critical Incident reports received requiring LME intervention, categorized by reason. **1915(c) waiver recipients only**
Crisis Plans (*) (+) The number and percentage of enrollees who are in need of a crisis plan and for whom a crisis plan has been developed, by category of need. **1915(c) waiver recipients only**

***Measures listed with an asterisk require a subset report for 1915(c) waiver enrollees.**

Attachment O

Requirements For Performance Improvement Projects

1. The LME shall develop and implement performance improvement projects as defined in Section 7.1 of the contract and in compliance with 42 CFR 438.240. The LME shall develop, implement, and report to DMA a minimum of two LME-specific and self-funded performance improvement projects the first year of this contract; one focusing on a clinical area and one focusing on a non-clinical area. A required non-clinical performance project for year one of the contract will be the development of an encounter data process that will accurately report services rendered to the enrollees of the LME. Project reports on all performance improvement projects shall be submitted to DMA no later than July 31st of each calendar year. For year two of the contract, the LME shall conduct a performance improvement project in addition to the two planned for the first contract year for a total of three. For year three of the contract, the LME shall conduct an additional performance improvement project for a total of four. The project topics will be determined jointly by the LME and DMA from the following clinical and non-clinical focus areas:
    - Primary, secondary and/or tertiary prevention of acute mental illness conditions;
    - Primary, secondary and/or tertiary prevention of chronic mental illness conditions;
    - Care of acute mental illness conditions;
    - Care of chronic mental illness conditions;
    - High-volume services;
    - High-risk services;
    - Continuity and coordination of care;
    - Availability, accessibility, and cultural competency of services;
    - Quality of provider/patient encounters;
    - Appeals, grievances, and other complaints;
2. Topics are identified through continuous data collection and analysis by the LME of comprehensive aspects of patient care and member services;
3. Topics are systematically selected and prioritized to achieve the greatest practical benefit for enrollees.
4. The Quality Assurance/Performance Improvement program provides opportunities for enrollees to participate in the selection of project topics and the formulation of project goals;
5. Assessment of the LME's performance for each selected topic is measured using one or more quality indicators. Quality indicators are objective, clearly and unambiguously defined and base on current clinical knowledge or health services research. Each project must represent the entire Medicaid enrollee population to which the specified measurement is relevant;
6. All indicators measure changes in health status, functional status, enrollee satisfaction or valid proxies of these outcomes;
7. The LME selects some indicators for which data are available that allow comparison of the LME's performance to that of similar Plans or to local, state, or national benchmarks;
8. The LME establishes a baseline measure of its performance on each indicator, measures changes in performance, and continues measurement for at least one year after a desired level of performance is achieved. Each project must have ongoing measurement and intervention and demonstrable and sustained improvement in significant aspects of clinical care and nonclinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction;
9. A project demonstrates significant improvement by achieving a benchmark level of performance defined in advance by CMS or DMA. Benchmarks will be based on currently accepted standards, past performance data, or available national data;
10. When sampling is used, sampling methodology for performance assessment shall be such as to ensure that the data collected validly reflect the performance of all practitioners and providers who serve Medicaid enrollees and whose activities are the subject of the indicator and the care given to the entire population (including special populations with special and complex health care needs) to which the indicator is relevant;
11. When a project measures performance on quality indicators by collecting data on a subset (sample) of the units of analysis in the population to be studied, significant improvement is demonstrated by achieving defined benchmarks using a sample that is sufficiently large to detect the targeted amount of improvement;
12. The sample or subset of the study population shall be obtained through random sampling;
13. The samples used for the baselines and repeat measurements of the indicators shall be chosen using the same sampling frame and methodology;

14. The demonstrated improvement is reasonably attributable to interventions undertaken by the LME (i.e., a project and its results have face validity);
15. The LME sustains the performance improvements for at least one year after the performance improvement is first achieved. Sustained improvement is documented through the continued measurement of quality indicators for at least one-year after the performance improvement project is completed;
16. The LME is expected to use measures to analyze the delivery of services or quality of care, over and under utilization of services, disease management strategies, and outcomes of care. The LME is expected to collect and use data from multiple sources such as medical record reviews, focused care studies, encounter data, HEDIS, claims processing, grievances, utilization review and member satisfaction surveys. DMA may specify the standard measures in uniform data collection and reporting instrument

ATTACHMENT P

GRIEVANCE AND APPEAL PROCEDURES

The LME shall have a timely and organized internal grievance system with written policies and procedures. The LME shall establish a grievance system for their Enrollees that meets all regulatory requirements, including a grievance process, an appeal process and access to the State's fair hearing system. The grievance process is the procedure of addressing Enrollee grievances. A grievance is an Enrollee's expression of dissatisfaction with any aspect of their care other than the appeal of actions, (which is an appeal). The Enrollee may file a grievance either orally or in writing.

A. General Requirements of Grievance System

The LME must:

1. Provide Enrollees any reasonable assistance in completing forms and other procedural steps not limited to providing interpreter services and toll free numbers with TTY/TDD and interpreter capability;
2. Acknowledge receipt of each grievance and appeal; and
3. Ensure that decision makers on grievance and appeals were not involved in previous levels of review or decision-making and who are health care professionals with clinical expertise in treating the member's condition or disease if any of the following apply:
    i. a denial appeal is based on lack of medical necessity;
    ii. a grievance regarding denial of expedited resolutions of an appeal or
    iii. any grievance or appeal involving clinical issues.

Pursuant to 42 C.F.R. 438.414, the LME must provide information on grievance, appeal, and fair hearing procedures and timeframes to all providers and subcontractors at the time they enter into a contract. The LME shall provide to Enrollees the following:

1. The Enrollee's right to a state fair hearing, how to obtain a hearing and representation rules at a hearing;
2. The Enrollee's right to file grievances and appeals and their requirements and timeframes for filing;
3. The availability of assistance in filing;
4. The toll free numbers to file oral grievances and appeals;
5. The Enrollee's right to request continuation of benefits during an appeal or State fair hearing filing and, if the LME's action is upheld in a hearing, the Enrollee may be liable for the cost of any continued benefits; and
6. Any State determined provider appeal rights to challenge the failure to the organization to cover a service.

B. Recordkeeping and Reporting

The LME must maintain records of grievances and appeals as follows.

1. The LME will maintain records that include a copy of the original grievance, the response, and the resolution.
2. Provide for retention of the records described, above, for five (5) years following a final decision or close of the grievance. If any litigation, claims negotiation, audit, or other action involving the records has been started before the expiration of the five (5) year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular five-year period, whichever is later.

ATTACHMENT P

C. Service Authorizations and Notices of Action

Action is defined in Attachment R, 1 as the:

1. Denial or limited authorization of a requested service (including the type or level of service);
2. Reduction, suspension, or termination of a previously authorized service;
3. Denial, in whole or in part, payment for a service;
4. Failure to provide services in a timely manner. The LME must ensure that appropriate services are available as stated in Section 6.5, Appointment Availability of this contract; or
5. Failure of the LME to act within the timeframes.

Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

The LME must notify the requesting provider and Enrollee of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice of adverse action to the provider need not be in writing, the Enrollee notice must be in writing.

The Notice of Adverse Action must explain:

a. The action the LME has taken or intends to take;
b. The reasons for the action;
c. The Enrollee's right to file an appeal;
d. How to contact the consumer relations or member services office and how to file an appeal with the LME;
e. The circumstances under which an expedited resolution is available and how to request it;
f. For Enrollees, the right to file an informal or formal appeal with the State pursuant to 10 NCAC 22H and how to obtain more information about those procedures; the circumstances under which health services must be continued;
g. For provider and subcontractors, the right to file an appeal with the State pursuant to 10 NCAC 22J;
h. That filing or resolving a grievance through the Plan's internal grievance system is not a prerequisite to filing an informal or formal appeal with the State pursuant to 10 NCAC 22H;
i. How to request that benefits be continued and the circumstances under which the Enrollee may be required to pay the costs of these services; pending resolution of the grievance, appeal or state fair hearing;
j. The right of the Enrollee in an informal appeal to represent himself or use legal counsel, a relative, a friend or other spokesman, and of the potential availability of free legal services;
k. That Enrollees have a right to a second opinion, at the LME's expense and
l. How to exercise that right;
m. The specific regulations that support, or the change in Federal or State law that requires, the notice of fair hearing.

The LME must make the information and notices described in this Appendix readily available orally and in writing in the recipient's primary language and in each prevalent non-English language in its service area. Written material must use easily understood language and format, be available in alternative formats and in an appropriate manner that takes into consideration those with special needs.
All Enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats. The LME must make these services available free of charge.

D. Timeframes for Notice of Action

1. Terminations, Suspension or Reduction of Services

   The LME gives notice at least ten (10) days before the date of action when the action is a termination, suspension or reduction of previously authorized Medicaid covered services, except:

   a. The period of advanced notice is shortened to five (5) days if probable recipient fraud has been verified;
   b. By the date of the action for the following:
      1. In the death of a recipient;
      2. A signed written recipient statement requesting service termination or giving information requiring termination or reduction of services (where he/she understands that this must be the result of supplying that information);
      3. The recipient's admission to an institution where he/she is ineligible for further services;
      4. The recipient's address is unknown and mail directed to him/her has no forwarding address;
      5. The recipient has been accepted for Medicaid services by another local jurisdiction State, territory, or commonwealth;
      6. The recipient's physician prescribes the change in the level of medical care;
      7. An adverse determination made with regard to the preadmission screening requirements for NF admissions on or after January 1, 1989; or,
      8. The safety or health of individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, an immediate or transfer is required by the resident's urgent medical needs, or a resident has not resided in the nursing facility for thirty (30) days (applies only to adverse actions for NF transfers.

2. Denial of Payment

   The LME gives notice on the date of action when the action is a denial of payment.

3. Standard Service Authorization Denial

   When the notice of action is a standard service authorization denial, the LME gives notice as expeditiously as the Enrollee's health condition requires and within DMA established timeframes that may not exceed fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if the Enrollee, requests extension; or the LME justifies a need for additional information and how the extension is in the Enrollee's interest (upon State request).

   If the LME extends the timeframe, it must give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a grievance if he or
   she disagrees with that decision; and issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

4. Expedited Service Authorization denial

   For cases in which a provider indicates, or the LME determines, that following the standard timeframe could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the LME gives notice must make an expedited authorization decision and provide notice as expeditiously as the Enrollee's health condition requires and no later than three (3) working days after receipt of the request for service.

   Extension -The LME may extend the three (3) working days time period by up to fourteen (14) calendar days if the Enrollee requests an extension, or if the LME justifies a need for additional information and how the extension is in the enrollee's interest (upon State request).

5. Untimely Service Authorization Decisions
The LME gives notice on the date that the timeframes expire when service authorization decisions not reached within the timeframes for either standard or expedited service authorizations. Untimely service authorizations constitute a denial and are thus adverse actions.

E. Appeal Process

1. Appeal
The LME must define appeal as the request for review of an "action", as defined in Attachment J, 1.3.

The Enrollee may file an LME level appeal.

2. Appeal process: Timing
The Enrollee may file an appeal within a reasonable timeframe that cannot be less than twenty (20) days and not to exceed ninety (90) days from the date on the notice of action.

3. Appeal Process: Procedures
The Enrollee may file an appeal either orally or in writing and must follow an oral filing with a written, signed appeal.

The PIHP shall:

a. Ensure that oral inquiries seeking to appeal an action are treated as appeals and confirm those inquiries in writing, unless the Enrollee requests expedited resolution;
b. Provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing;
c. Allow the Enrollee and representative opportunity, before and during the appeals process, to examine the Enrollee's case file, including medical records, and any other documents and records;
d. Consider the Enrollee, representative, or estate representative of a deceased Enrollee as parties to the appeal.

4. Appeal process: Resolution and Notification
The PIHP must resolve each appeal, and provide notice, as expeditiously as the Enrollee's health condition requires, within State established timeframes not to exceed forty five (45) days from the day the LME receives the appeal.

5. Extension
Timeframes for Standard Authorization Decisions or Standard Authorization Denial: Notice must be provided as expeditiously as the Enrollee's health condition requires, but may not exceed 14 calendar days following receipt of the request for services, with a possible extension of up to 14 additional calendar days if the enrollee or the provider requests extension, or the LME documents a need to DMA for additional information and that the extension is in the Enrollee's interest.

6. Requirements following extension
For any extension not requested by the enrollee, the LME must give the Enrollee written notice of the reason for the delay.

7. Appeal Process: Format and content of resolution notice
The LME must provide written notice of disposition. The written resolution notice must include:

a. The results and date of the appeal resolution.
b. For decisions not wholly in the Enrollee's favor:
    1. The right to request a State fair hearing,

2. How to request a State fair hearing,
3. The right to continue to receive benefits pending a hearing,
4. How to request the continuation of benefits, and
5. If the LME's action is upheld in a hearing, the Enrollee may be liable for the cost of any continued benefits.

8. Appeal and State Fair Hearing Process: Continuation of benefits
The MCO or PIHP must continue the Enrollee's benefits if:

a. The appeal is filed timely, meaning on or before the later of the following:
   1. Within ten (10) days of the LME mailing the notice of action;
   2. The intended effective date of the Plan's proposed action.
b. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
c. The services were ordered by an authorized provider;
d. The authorization period has not expired; and
e. The Enrollee requests extension of benefits.

9. Appeal and State Fair Hearing process: Duration of continued or reinstated benefits
If the LME continues or reinstates the Enrollee's benefits while the appeal is pending, the benefits must be continued until one of following occurs:

f. The Enrollee withdraws the appeal;
g. The Enrollee does not request a fair hearing within ten (10) days from when the LME mails an adverse LME decision;
h. A State fair hearing decision adverse to the Enrollee is made;
i. The authorization expires or authorization service limits are met.

10. Appeal and State fair hearing process: Enrollee responsibility for services furnished while the appeal is pending.
The LME may recover the cost of the continuation of services furnished to the Enrollee while the appeal was pending if the final resolution of the appeal upholds the LME's action.

11. Appeal and State fair hearing process: Effectuation when services were not furnished
The LME must authorize or provide the disputed services promptly, and as expeditiously as the Enrollee's health condition requires if the services were not furnished while the appeal is pending and the LME , or the State fair hearing officer reverses a decision to deny, limit, or delay services.

12. Appeal and State fair hearing process: Effectuation when services were furnished
The LME or the State must pay for disputed services, in accordance with State policy and regulations, if the LME, or the State fair hearing officer reverses a decision to deny authorization of services, and the Enrollee received the disputed services while the appeal was pending.

F. Expedited Appeal Process – General.

The LME must establish and maintain an expedited review process for appeals, when the LME determines (for a request from the member) or the provider indicates (supporting the Enrollee's request) that taking the time for a standard resolution could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function.

Expedited appeals are just a "special type" of appeals. The LME is required to follow all standard regulation appeal regulations for expedited requests except where differences are specifically noted in the regulation for expedited resolution.

1. Expedited Appeal Process – Authority to File.
   The Enrollee may file an expedited appeal either orally or writing. No additional Enrollee follow-up is required.

2. Expedited Appeal Process – Procedures
   The LME must inform the Enrollee of the limited time available for the Enrollee to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.

3. Expedited Appeal Process: Resolution and Notification
   The LME must resolve each expedited appeal and provide notice, as expeditiously as the Enrollee's health condition requires, within State-established timeframes not to exceed three (3) working days after the LME receives the appeal.

   Requirements following extension - for any extension not requested by the Enrollee, the LME must give the member written notice of the reason for the delay.

4. Expedited Appeal Process: Format of resolution notice
   In addition to written notice, the LME must also make reasonable efforts to provide oral notice.

5. Expedited Appeal Process: Punitive action
   The LME must ensure that punitive action is not taken against a provider who either requests an expedited resolution or supports an Enrollee's appeal.

6. Expedited Appeal Process: Action following denial of a request for expedited resolution
   If the LME denies a request for expedited resolution of an appeal, it must:

   a. Transfer the appeal to the standard timeframe of no longer than forty five (45) days from the day the LME receives the appeal with a possible fourteen (14) day extension;
   b. Give the Enrollee prompt oral notice of the denial (make reasonable efforts) and a written notice within two (2) calendar days. The notice should include the information listed under Section C, Service Authorizations and Notices of Action, of this document and Notice of Adverse Action included in Section C of this document.
   c. Other information for enrollees and providers would include:

      1. An Enrollee may request a State fair hearing;
      2. The State must permit the Enrollee to request a State fair hearing within a reasonable time period specified by the State, but not less than twenty (20) or in excess of ninety (90) days from whichever of the following dates applies:

         a. If the State requires exhaustion of the LME level appeal procedures and the Enrollee appeals directly to the State for a fair hearing, from the date on the LME's notice of action.

b. The State must reach its decisions within the specified timeframes: Standard resolution: within ninety (90) days of the date the Enrollee filed the appeal with the Plan if the Enrollee filed initially with the LME (excluding the days the Enrollee took to subsequently file for a State fair hearing) or the date the enrollee filed for direct access to a State fair hearing.
c. Expedited resolution (if the appeal was heard first through the LME appeal process): within three (3) working days from agency receipt of a hearing request for a denial of a service that:

    1. Meets the criteria for an expedited appeal process but was not resolved expedited appeal timeframes, or were resolved wholly or partially adversely to the enrollee using the LME's expedited appeal timeframes.

Attachment Q

Network Provider Qualifications

Competency of the Provider Network

The goal of the Piedmont LME is to develop a provider network that provides services which are culturally competent, composed of providers that demonstrate competencies in best practices and consumer outcomes, providers that will ensure health and safety for consumers, and providers that demonstrate ethical and responsible practices. The LME is committed to the achievement of outcomes for consumers and consumer satisfaction, to the development of a system that ensures quality indicators are on target, and a system that ensures providers comply with network requirements.

Types of Providers anticipated for the Piedmont Network:

Comprehensive Community Providers (CCPs): Comprehensive Community Providers will be identified or developed. Comprehensive providers are agency-based entities providing a number of different services, including enrollment, and serving at least two disability areas.

The Comprehensive Community Provider must have offices and service locations within the LME catchment area. Piedmont will develop over the course of this contract, at least two agencies in each of the four counties to ensure that consumers will have a choice of enrollment sites.

Comprehensive Community Providers will be designated points of entry to ensure easy access for consumers. Consumers will be able to make appointments or "walk in" to these locations in order to be enrolled in services. The CCP's must have the information system infrastructure to link to the LME electronically and will conduct critical functions in providing enrollment information to the LME. They will be responsible for completing initial assessments as part of the enrollment and needs determination process.

Specialty Providers: Specialty providers are providers that specialize in a specific service (such as vocational or residential) or in serving a specific disability area, or both. Specialty providers are important components of the network because they can focus their efforts on best practice strategies for a specific population. Piedmont intends to develop this aspect of the network in order to ensure best practice options for consumers. Piedmont has a number of specialty providers and expects to increase the number of these agency-based entities as the Network is developed, in order to insure choices for recipients.

Licensed Practitioners and Professional Practice Groups: Licensed Practitioners in the areas of Medicine, Psychology, and Social Work will be recruited as an arm of the Piedmont Provider network. Licensed Practitioners provide Outpatient services such as psychiatric care, assessment and outpatient therapy. Consumers will be offered a choice of independent practitioners or Comprehensive Community Provider agencies when calling the Access line and requesting services.

Agency Provider Criteria for Enrollment:

1. Providers shall have valid a North Carolina license (if applicable for type of provider) before applying to the network. The LME must verify.
2. Providers shall complete an application to join the network, agreeing to comply with all network requirements for reporting, inspections, monitoring, consumer choice requirements, to participate in corporate compliance and the network continuous quality improvement process.
3. Providers shall disclose any sanctions under the Medicare or Medicaid programs including paybacks, lawsuits, insurance claims or payouts, and disciplinary actions of the applicable licensure boards or adverse actions by regulatory agencies within the past five years.
4. Providers shall disclose any actions listed in #3, which are pending.
5. The Provider shall furnish the LME a history of names if the entity has done business under other names or is using a DBA (doing business as) name.
6. The Provider shall identify ownership of the entity. A list of all owners of more than 10% interest and a list of all parent, sister, and subsidiary entities in the entire chain of ownership, including an organizational flow chart, up to the ultimate owner of the holding company shall be provided.
7. The Provider shall furnish the LME a list of all the members of the Board of Directors and addresses of the entity and of any parent, sister or subsidiary entities.
8. The Provider shall disclose if the entity is affiliated by contract or otherwise, with any other provider.
9. For Non-profit corporations, the Provider shall delineate members if a member corporation. If the Provider is a non-member corporation, a list of its Board of Directors and addresses shall be submitted to the LME.
10. The Provider shall supply references, which will be evaluated by the LME..
11. The Provider shall have a no reject policy of patients within the capacity and the parameters of their competencies. Providers shall agree to accept all referrals meeting criteria for services provided when they have available capacity; a provider's competency to meet individual referral needs will be negotiated between the LME and the provider.
12. The Provider agency shall demonstrate experience and competency. Stability of past operations is important. An assessment of the agency's past record of services, compliance with applicable laws, standards and regulations, the qualifications and competency of its staff, the satisfaction of consumers and family members served, systems of oversight, adequacy of staffing infrastructure, use of best practices, and quality management systems will be evaluated by the LME prior to enrollment and at regular intervals thereafter.
13. The Provider Agency shall be able to send 837 HIPAA compliant transactions and to receive 835 Remittances or to participate in the LME's web based billing process.
14. The Provider shall demonstrate consumer friendly services and attitude. During the application process, providers shall demonstrate how consumers and families are involved in treatment and services. The Provider shall have a good system of communication with consumers.
15. Provider agencies shall have the clinical infrastructure either through their own agency or through collaborations with other providers to address challenges in meeting specific client needs (such as challenging behaviors or medical problems). The LME will not be staffed to provide this consultation.
16. The Provider shall have the capacity to respond to emergencies for assigned consumers according to contract requirements. If required, an adequate clinical back up system shall be in place to respond to emergencies after hours and on weekends.
17. The Provider shall demonstrate systems to ensure fiscal responsibility and integrity.
18. The Provider shall submit documentation of Insurance coverage that meets minimum requirements of this Contract. Providers shall have applicable Medical Malpractice insurance.
19. The Provider's staff are appropriately credentialed and or have attained required competencies.

In order to achieve cultural competency, it is important for the Piedmont Network of Providers to have a diversity of providers and staff. Piedmont Network Providers shall develop the capacity to provide culturally competent services and ensure the cultural sensitivity of its staff. This can be accomplished by participation in the LME's Cultural Competency Plan, which is under development. This requirement shall be met within the strictures of state and federal laws, which require equal opportunity in employment and bar illegal employment discrimination on the grounds of race, gender, religion, national origin or disability.

Maintaining Network Membership:

Additional factors such as those delineated below and/or other factors such as participation in the Quality Improvement process, shall be considered in maintaining agencies within the provider network. Performance Indicators shall be developed to reflect these requirements, following the establishment of baseline performance levels.

1. Acceptance rate for referrals is within established limits.
2. Turnover/discharge rate (by reason) for consumers is within acceptable limits.
3. Consumer Satisfaction is within acceptable limits.
4. Demonstrated responsiveness to consumer complaints is within acceptable limits.
5. Record of response to emergent, urgent, and routine referrals and record of scheduled and unscheduled wait times is within acceptable limits.
6. Record of incidents/abuse/neglect and compliance with mandated reporting is within acceptable limits.
7. Performance on Quality Measures is within acceptable limits.
8. Staff turnover rates are within established acceptable limits.
9. Most emergencies are managed within the agency. Look behind review of requests for outside assistance indicates acceptable reasons for outside referral.
10. Overall report card performance is within acceptable limits.
11. Results of financial audits indicate no problems in management of funds.
12. There is no record of any sanctions under the Medicare or Medicaid program.
13. A review of sanctions under the Medicare or Medicaid programs, as well as the agency's record of compliance with documentation and billing requirements, its record of required paybacks, lawsuits, insurance claims or payouts, and disciplinary actions of the applicable licensure boards or adverse actions by regulatory agencies within the past five years shall yield acceptable results.

Process for Determining Initial Provider Qualifications and Ongoing Monitoring Activities of the LME:

Initial Enrollment: The following system for initial enrollment was developed based on parameters identified by the LME's Consumer Family Advisory Committee during the Local Business Planning Process:

a. If a licensed agency, the LME shall verify the license.
b. The LME shall conduct a qualifying review to assess the provider's compliance, competencies and qualifications. This review shall include verification of the organizations' ability to meet LME Network Requirements as well as competency in the areas of administrative, financial, clinical, rights, consumer/family satisfaction and involvement, quality improvement and information services capacity. The review shall also determine whether the organization has qualified staff and policies and procedures in place to meet program requirements for the services to be provided. Standard areas include: procedures, service documentation/records, personnel qualifications, training, supervision and background checks, medication administration, confidentiality and client rights. A Plan of Correction shall be required for deficit areas prior to enrollment in the network. Failure to complete an appropriate plan of correction may result in a denial to enter the network (or removal from the Network).
c. If there is a competitive Request for Proposal Process, a scoring process shall be developed that shall include results of consumer and stakeholder interviews.
d. For all initial enrollments, the LME shall complete an on-site Treatment Plan Implementation and Clinical Competency Review within 6 months of service initiation.

Maintenance in the LME Network:

Maintenance of Agency Providers depends on the performance of the agency as measured against identified indicators and benchmarks as indicated above, as well as needs as identified in the annual Network Capacity assessment. A provider's performance shall be routinely measured through LME Monitoring and through the

Continuous Quality Improvement Process. Provider performance shall be reported and evaluated by the LME's Global Quality Improvement Committee, Clinical Advisory Committee, the Network Council, and the Consumer Family Advisory Committee.

Enrollment of Licensed Practitioners:

Licensed Practitioners shall be enrolled based on meeting the following requirements:

1. Licensed Practitioners shall meet state licensure requirements and hold a valid North Carolina license.
2. Independent verification of credentials shall be required, including primary source verification.
3. Insurance coverage shall meet minimum requirements.
4. Providers will be encouraged to submit electronic claims directly or through a billing service.
5. A provider's on-call designee shall be a member of the network or approved by the LME.
6. Licensed practitioners shall complete an application to provide services that addresses in part the following:
    - History of loss of license and/or criminal convictions; actions by licensing board
    - Names of hospitals at which the practitioner has had admitting privileges (physicians)
    - History of loss or limitation of privileges or disciplinary activity (physicians)
    - Languages spoken proficiently
    - At least two peer references
    - Areas of specialized practices
    - Agreement to participate in the Piedmont Network and to participate in the quality improvement program.

7. The Licensed Practitioner shall disclose any sanctions under the Medicare or Medicaid programs including paybacks, lawsuits, insurance claims or payouts, and disciplinary actions of the applicable licensure boards or adverse actions by regulatory agencies within the past five years.
8. The Licensed Practitioner shall disclose any actions listed in #7 which are pending.

The LME shall independently verify from original sources the Educational and Licensure status of the Licensed Practitioner as well as whether sanctions under the Medicare or Medicaid programs have been levied.

Maintenance of Licensed Practitioners in the Network:

The following factors will be evaluated in the ongoing membership in the Provider Network.

1. Referral acceptance rate.
2. Consumer satisfaction
3. The provider will be re-credentialed based upon standards for the provider type with the timeframe not to exceed every 3 years. At that time the LME will examine the performance record of the licensed practitioner, as well as review satisfaction data, outcome data, results of any audits, peer reviews or other reviews of the provider's services.
4. The LME will review any history of loss or limitation of privileges or disciplinary activity of any provider.
5. The LME will inquire whether there have been any sanctions under the Medicare or Medicaid programs including paybacks, lawsuits, insurance claims or payouts, and disciplinary actions of the applicable licensure boards or adverse actions by regulatory agencies within the past five years.

ATTACHMENT R

CAPITATION RATES AND RATE SETTING METHODOLOGY

CAPITATION RATES:

Rate Setting Methodology #1 — Use of Historical Fee-For-Service Data

Initially for the Piedmont LME Project, the rates will be calculated using a fee-for-service (FFS) data source. This will allow for the collection of managed care encounter and financial data for the first two years of the program.

To develop capitation rates on an actuarially-sound basis for the Piedmont LME using historical FFS data, the following general steps are performed:

1. Summarize the FFS Claims and Eligibility Data.
2. Combine the Multiple Years of FFS Data Together,
3. Project the FFS Base Data Forward,
4. Include the Effect of Program/Policy Changes, and
5. Adjust the FFS Data to Reflect Managed Care Principles.

Summarize the FFS Claims and Eligibility Data — DMA provides FFS claims and eligibility data for the recipients and services to be covered under the Piedmont LME. Normally, three years of FFS data are made available for rate-setting purposes. This data is then adjusted to account for items not included in the initial FFS data collection process. These adjustments (positive and negative) generally include, but are not limited to: completion factors, cost settlements, removal of graduate medical education payments, removal of disproportionate share hospital payments, and other adjustments needed to match the coverage responsibilities of the Piedmont LME.

Combine the Multiple Years of FFS Data Together — To arrive at a single year of FFS data to serve as the basis for rate setting, the multiple years of FFS data are combined together. Through this process, the older data is projected forward to be comparable to the most recent information. All the data is then blended together to form a single set of base data (with the most recent year of data receiving more weight).

Project the FFS Base Data Forward — The blended base data is then projected forward to the time period for which the capitation rates are to be paid. Trend factors are used to estimate the future costs of the services that the covered population would generate in the FFS program. These trend factors normally vary by service and/or population group.

Include the Effect of Program/Policy Changes — DMA may occasionally change the services or populations covered under the Piedmont LME. These changes are included in the capitation rates by either increasing or decreasing the FFS data by a certain percentage amount.

Adjust the FFS Data to Reflect Managed Care Principles — Since the Piedmont LME is a managed care program and not FFS, the projected FFS data needs to be adjusted to reflect the typical changes that occur when changing from a FFS program to a managed care program. This generally involves increasing the utilization of preventative services, and decreasing hospital and emergency room utilization. To compensate the managed care plans for managing and coordinating the care of their Members, an additional administration amount is added to arrive at the final capitation rates.

II. Rate Setting Methodology #2 — Use of Managed Care Data

Likely in the third or fourth year of the program, credible managed care encounter and financial data will become available for rate-setting. Once this data is validated, managed care data will become the base data source for all future rate-setting years.

To develop capitation rates on an actuarially-sound basis for the Piedmont LME using actual managed care data, the following general steps are performed:

1. Summarize, Analyze, and Adjust The Managed Care Data,
2. Project the Managed Care Base Data Forward,
3. Include the Effect of Program/Policy Changes, and
4. Add an Appropriate Administration Load.

Summarize, Analyze, and Adjust the Managed Care Data — DMA will collect data from the Piedmont LME. This data is summarized, analyzed, and adjustments (positive and negative) are applied, as needed. These adjustments can account for items such as collection of third-party liability/coordination of benefits (TPL/COB), over- or under-reserving of unpaid claims, management efficiency, and provider contracting relations. After adjusting Piedmont's data, Piedmont's medical claims costs are aggregated together to arrive at a set of base data for each population group.

Project the Managed Care Base Data Forward — The aggregate base of managed care data is projected forward to the time period for which the capitation rates are to be paid. Trend factors are used to estimate the future costs of the services that the covered population would generate in the managed care program. These trend factors normally vary by service and/or population group.

Include the Effect of Program/Policy Changes — DMA may occasionally change the services or populations covered under the Piedmont LME. Any new program/policy changes that were not already reflected in the managed care data are included in the capitation rates by either increasing or decreasing the managed care data by a certain percentage amount.

Add an Administration Load — After the base data has been trended to the appropriate time period, and adjusted for program/policy changes, an administration load will be added to the medical claim cost component to determine the overall capitation rates applicable to each population group. The administration load is applied as a percentage of the total capitation rate (e.g., percent of premium) and does not vary by population group.

III. Rate Setting Methodology #3 – Blending of FFS and Managed Care Data

If updated FFS data is unavailable and actual managed care experience first becomes available (year 3 of the program), capitation rates for the Piedmont LME can be developed on an actuarially-sound basis using a blending of both data sources using the following two track approach:

1. Project the Prior Year's Rates Forward (Track 1),
2. Summarize and Adjust the Managed Care Data (Track 2),
3. Include the Effect of New Program/Policy Changes and Trend (Track 1 and Track 2), and
4. Apply Credibility Factors to Each Track and Blend Together.

Project the Prior Year's Rates Forward (Track 1) — The first step of Track 1 is to begin with the previous year's capitation rates that were originally developed using historical FFS claims and eligibility data. This data is projected forward to the time period for which the new capitation rates are to be paid. Trend factors are used to estimate the future costs of the services the covered population would generate under managed care. These trend factors normally vary by service and/or population group.

Summarize and Adjust the Managed Care Data (Track 2) — The more recent managed care data is collected from Piedmont, summarized, and analyzed to support rate setting. Adjustments (positive and negative) are applied to the managed care data as needed. These adjustments can account for items such as collection of TPL/COB, over- or under-reserving of unpaid claims, management efficiency, and provider contracting relations.

Include the Effect of New Program/Policy Changes (Track 1) — In Track 1, any new program/policy changes implemented by DMA , that were not already accounted for in the previous year's rates, are included in the new capitation rates by either increasing or decreasing the rates by a certain percentage amount. An additional administration amount is added to arrive at the final capitation rates under Track 1.

Include the Effect of Trend and New Program/Policy Changes (Track 2) — In Track 2, the managed care data is projected forward to the time period the capitation rates are to be paid. Trend factors may vary by service and/or population group, and are used to estimate the future costs of the services that the covered population would generate under managed care. Any new program/policy changes that were not already reflected in the managed care data are included in the rates by either increasing or decreasing the data by a certain percentage amount. An additional administration amount is added to arrive at the final capitation rates under Track 2.

Apply Credibility Factors to Each Track and Blend Together — After separately developing capitation rates using Track 1 and Track 2, the two sets of rates are combined together. This blending involves applying a credibility weight to each track (e.g., 50/50 split) and adding the two components together. The credibility weights may vary between the population groups.

ATTACHMENT S

BUSINESS TRANSACTIONS

All PIHPs which are not Federally qualified, shall disclose to DMA information on certain types of transactions they have with a "party in interest" as defined in the Public Health Service Act. (See Sections 1903(m)(2)(A)(viii) and 1903(m)(4) of the Act.)

A. Definition of a Party in Interest - As defined in Section 1318(b) of the

Public Health Service Act, a party in interest is:

(1) Any director, officer, partner or employee responsible for management or administration of a PIHP; any person who is directly or indirectly the beneficial owner of more than five (5) % of the equity of the PIHP ; any person who is the beneficial owner of more than five (5) % of the PIHP or, in the case of a PIHP organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation laws;

(2) Any organization in which a person described in subsection 1 is director, officer or partner; has directly or indirectly a beneficial interest of more than five (5)% of the equity of the PIHP ; or has a mortgage, deed of trust, note, or other interest valuing more than five (5) % of the assets of the PIHP ;

(3) Any person directly or indirectly controlling, controlled by, or under common control with a PIHP ; or

(4) Any spouse, child, or parent of an individual described in subsections 1, 2, or 3.

B. Types of Transactions Which Must Be Disclosed - Business transactions which must be disclosed include:

(1) Any sale, exchanges or lease of any property between the PIHP and a party interest;

(2) Any lending of money or other extension of credit between the PIHP and a party interest; and

(3) Any furnishing for consideration of goods, services (including management services) or facilities between the PIHP and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

C. The information, which must be disclosed in the transactions, listed in subsection B between a PIHP and a party in interest includes:

(1) The name of the party in interest for each transaction;
(2) A description of each transaction and the quantity or units involved;
(3) The accrued dollar value of each transaction during the fiscal year; and
(4) Justification of the reasonableness of each transaction.

If this PIHP contract is being renewed or extended, the PIHP must disclose information on these business transactions, which occurred during the prior contract period. If the contract is an initial contract with Medicaid, but the PIHP has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period must be disclosed. The business transactions, which must be reported, are not limited to transactions related to serving the Medicaid enrollment. All of these PIHP business transactions must be reported.

ATTACHMENT T

PROVIDER MANUALS, BULLETINS and CLINICAL COVERAGE POLICIES

Medicaid Community Care Manual - Available on DMA web site*

Medicaid Durable Medical Equipment Manual - Available on DMA web site*

Medicaid Hospital Services Manual - Available on DMA web site*

General Medicaid Billing/Carolina ACCESS Policies and Procedures Guide, August, 2003 – available on DMA web site*

Medicaid Bulletins: general and specific – Available on DMA website*

Transportation – DMA Administrative Letter No 01-95, July 1, 1994; July 15, 1994; October 15, 1995

Administrative Procedures Services Manual 30-1

Administrative Procedures Services Manual 45-2

Administrative Procedures Services Manual 95-1

Mental Health, Developmental Disabilities and Substance Abuse Services Clinical Coverage Policy

***DMA Web Site address to access online Manuals, Bulletins and Clinical Coverage Policies: http://www.dhhs.state.nc.us/dma/**

Attachment U

Access/Availability Standards

ACCESSIBILITY

A. Geographic Location
   1. The Provider Network for all covered in-plan services must be as geographically accessible to Medicaid enrollees as to non-Medicaid enrollees.

B. Distance/Travel Time
   1. Medicaid enrollees should have access to Network Providers within thirty (30) miles distance or thirty minutes drive time, 45 miles or 45 minutes in rural areas. Longer distances as approved by DMA are allowed for facility based or specialty providers.

C. Facility Accessibility
   Contracted provider facilities must be accommodating for persons with physical disabilities. The LME must observe for handicapped parking and entrance ramps; wheelchair accommodating door widths; and bathrooms equipped with handicapped railing.

D. New Enrollee Orientation
   Enrollee materials and information shall be sent to each new enrollee by the LME within fourteen (14) days of effective date of enrollment.

E. Enrollee Services
   Medicaid enrollees must have toll-free telephone access to a Customer Services department to provide assistance, information, and education to members.

F. Support Services
   1. Transportation-
      Assistance with arrangement for transportation to medically necessary services through public and private means must be made available and communicated to Medicaid enrollees.

   2. Interpreters-
      Language interpretation services must be made available by telephone and/or in person enabling Medicaid enrollees to effectively communicate with the LME and providers. TDD (telecommunication devices for the deaf) must also be made available for persons who have impaired hearing or a communication disorder.

AVAILABILITY

A. Appointments
   1. Emergency care- within one hour
   2. Urgent care- within forty-eight (48) hours
   3. Routine care- seven (7)

B. Office Wait Times
   1. Walk-in- within two (2) hours;
   2. Scheduled appointment- within one (1) hour;
   3. Emergencies- within one hour; life threatening emergencies, immediately.

C. After Hours Emergency and Referral
   1. The LME will provide toll-free telephone emergency and referral line twenty four (24) hours per day.

   2. Return Calls to Enrollees- Telephone inquiries made by members after hours for access/information must be responded to within one (1) hour of receiving the call.

D. The Enrollee has a right to a second opinion from a qualified health care professional within or outside the network, at no cost to the enrollee

Attachment V

GUIDELINES FOR STABILIZATION EXAMINATION AND TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND WOMEN IN LABOR

(a) SEC. 1867. [42 U.S.C. 1395dd] (a) MEDICAL SCREENING REQUIREMENT--In the case of a hospital that has a hospital emergency department, if any individual (whether eligible or not for benefits under this title) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists.

(b) NECESSARY STABILIZING TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND LABOR--

(1) IN GENERAL--If any individual (whether or not eligible for benefits under this title) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either--

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c).

(2) REFUSAL TO CONSENT TO TREATMENT--A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment

(3) REFUSAL **TO CONSENT TO TRANSFER--**A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.

(c) RESTRICTING TRANSFERS UNTIL INDIVIDUAL STABILIZED--

(1)RULE.--If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B)), the hospital may not transfer the individual unless--

(A) (i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility.

(ii) a physician (within the meaning of section 1861(r)(1)) has signed a certification that based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh

the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or

(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1861(r)(1)), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and

(B) the transfer is an appropriate transfer (within the meaning of paragraph 2)) to that facility. A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.

(2) APPROPRIATE TRANSFER--An appropriate transfer to a medical facility is a transfer—

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(B) in which the receiving facility--
(i) has available space and qualified personnel for the treatment of the individual, and
(ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call
physician (described in subsection (d)(1)(C)) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

(D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

(d) ENFORCEMENT

(1) CIVIL MONETARY PENALTIES—

(A) A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than fifty thousand ($50,000) or not more than twenty-five thousand ($25,000) in the case of a hospital with less than one hundred (100) beds) for each such violation. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1128A(a).

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who—

(i) signs a certification under subsection (c)(1)(A) that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

(ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section, is subject to a civil money penalty of not more than fifty thousand ($ 50,000) for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in the title and State health care programs. The provisions of section 1128A (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1128A(a).

(C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1866(a)(1)(I)) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.

(2) CIVIL ENFORCEMENT--

(A) PERSONAL HARM--Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(B) FINANCIAL LOSS TO OTHER MEDICAL FACILITY--Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(C) LIMITATIONS ON ACTIONS--No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(3) CONSULTATION WITH PEER REVIEW ORGANIZATIONS--In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1), the Secretary shall request the appropriate utilization and quality control peer review organization (with a contract under part B of title XI) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least sixty (60) days for such review.

(e) DEFINITIONS--In this section:

(1) The term "emergency medical condition" means—

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in--

(i) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) Serious impairment to bodily functions, or

(iii) Serious dysfunction of any bodily organ or part; or

(B) With respect to a pregnant women who is having contractions--

(i) That there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) That transfer may pose a threat to the health or safety of the woman or the unborn child.

(2) The term "participating hospital" means hospital that has entered into a provider agreement under section 1866.

(3)(A) The term "to stabilize" means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

(B) The term "stabilized" means, with respect to an emergency medical condition described in outside a hospital's facilities at the direction of any person employed by (or paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

(4) The term "transfer" means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual whom:

(A) Has been declared dead; or

(B) Leaves the facility without the permission of any such person.

(5) The term "hospital" includes a critical access hospital (as defined in section 1861(mm)(1)).

(f) PREEMPTION--The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

(g) NONDISCRIMINATION--A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units), or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

(h) NO DELAY IN EXAMINATION OR TREATMENT--A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) or

further medical examination and treatment required under subsection (b) in order to inquire about the individual's method of payment or insurance status.

(i) WHISTLEBLOWER PROTECTIONS--A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.

(ii)

ATTACHMENT W
MIXED SERVICES PROTOCOL

Services	**Claim Processing And/Or Financial Liability**
Inpatient Room Charges	
Mental Health and Substance Abuse Behavioral Health Event (including detoxification).	LME
Inpatient Mental Health and Substance Abuse Professional Services	LME
Other medical services	Medical Plan
Inpatient/Outpatient X-ray and Lab Work	
Prescribed by an LME network provider on an Inpatient basis such as VDRL, SMA, CBC, UA (urinalysis), Cortisol, x-rays for admission physicals, therapeutic drug levels.	Medical Plan
Prescribed by LME network provider on an outpatient basis such as therapeutic drug levels.	Medical Plan
Ordered for evaluation of medical problems or to establish organic pathology, cat scans thyroid studies, EKG etc. or any tests ordered prior to having a patient medically cleared.	Medical Plan
Other tests ordered by non-LME physician	Medical Plan
Drugs	
Outpatient prescription drugs and take home drugs.	Medical Plan
Ambulance	
Transport to the hospital when the primary diagnosis is behavioral care	Medical Plan
Transport to a hospital prior to a medical emergency when the primary diagnosis is medical	Medical Plan
Transfers authorized by LME from non-network facility to a network facility	LME
Consults	
Mental Health or Alcohol/Substance Abuse on Medical Surgical Unit	LME
Mental Health or Alcohol/Substance Abuse in a Nursing Home or Assisted Living Facility	LME

Services	Claim Processing And/Or Financial Liability
Medical/Surgical on Mental Health/Substance Abuse Unit	Medical Plan
Emergency Room Charges – Professional Services	
Emergency Mental Health, Alcohol/Substance Abuse services provided by MH/SA practitioners	LME
Emergency medical/surgical professional services other than detoxification (e.g. lab work, x-rays, medical treatment).	Medical Plan
Emergency Room Facility Charge.	
Primary mental health, alcohol, or substance abuse diagnosis even if final discharge is Behavioral Health	Medical Plan
Primary medical diagnosis (other than detoxification); medical stabilization for attempted suicide	Medical Plan
Medical/Neurological/Organic Issues	
Stabilization of self-induced trauma poisoning.	Medical Plan
Treatment of disorders which are primarily neurologically/organically based, including delirium, dementia, amnesic and other cognitive disorders.	Medical Plan
Miscellaneous	
Pre-Authorized, Mental Health, Alcohol/Substance Abuse admission, History and Physical	LME
Adjunctive alcohol/substance abuse therapies when specifically ordered by a network or LME authorized physician	LME
Alcohol Withdrawal Syndrome and Delirium Tremens	
Alcohol withdrawal syndrome. Ordinary Pharmacologic syndrome characterized by Elevated vital signs, agitation, perspiration, Anxiety and tremor that is associated with the abrupt cessation of alcohol or other Addictive substances. Detoxification services authorized by LME. Not included: fetal alcohol Syndrome or other symptoms exhibited by newborns whose mothers abused drugs.	LME
Delirium tremens (DTs), which is a complication of chronic alcoholism associated with poor nutritional status. This is characterized by a major physiologic and metabolic disruption and is accompanied by delirium (after persecutory hallucination), agitation, tremors (frequently seizures) high temperatures and may be life-threatening.	Medical Plan

Attachment X
FINANCIAL REPORTING REQUIREMENTS

	REPORT	FREQUENCY	REQUIREMENTS
1.	Enrollment Table Report	Quarterly report due 60 days following end of the quarter Annual report due 90 days from the end of the year.	Total Eligibles Report by Eligiblity Category and Eligibles in Service. Number of Retroactive eligibility. Quarterly Reconciliation of eligibles with payments.
2.	Related Party Transactions and Obligations	Annual	Do not have Related Parties. Annual Certification that Related Party Transactions/relationships do not exist.
3.	Risk Pool Analysis	Annual	End of year reconciliation to be addressed in the Annual Audit
4.	IBNR (Claims lag report)	Quarterly	Include the following: • Month paid • Dates of services (months) • Total paid for month • Less; estimated total claims expense (total expense = 100%) • Estimated IBNR = "0" (Total paid for month less estimated total claims expense plus adjustments) • On column for greater than 180 days
5.	Claims Processing report	Quarterly	Clean Claims, Pended Claims, Approved but unpaid Claims, Denied Claims: number received and amount paid, pended, unpaid, and denied. Include reporting on Prompt Pay Requirements.
6.	Analysis of Revenues and Expenses	Quarterly	Revenue and expenses by major program category. Admin accounted for separately and quarterly cost allocation.
7.	Coordination of Benefits	Monthly	837 COB/CAS
8.	Reinvestment Report	Annual	Based on savings from expenses.
9.	Statement of Financial Position (Balance Sheet)	Quarterly	Assets, other debits, liabilities, fund equity and other credits
10.	Statements of Activities	Quarterly	Included on Balance Sheet
11.	Statement of Activities and Changes in Net Assets	Annual	Balance Sheet in Annual audit
12.	Retained Earnings (Deficit)/Fund Balance	Annual	Balance Sheet in Annual Audit
13	Statement of Cash Flows	Annual	Audit
14.	Independent Audit—financial audit and supplemental schedules	Annual	Per requirements in Contract
15.	Statement of Financial Position Reconciliation	Annual	Audit
16.	OMB Circular A-133	Annual	Audit
17.	Annual Disclosure Statement	Annual	Audit
18.	Cost Allocation Plan	Annual	60 days prior to beginning of fiscal year.
19.	Physician Incentive Arrangement (if any)	Annual	Physicians at risk over 25% of salary; ensure that care is not limited by this incentive.

Attachment X – Financial Reporting Requirements

The following sample reports reflect agreement on report content and formats:

 # 9, 10, 11: SAMPLE Balance Sheet:

Cash and cash equivalents	$ 15,386,329
Receivables:	
Accounts Receivable	790,909
Sales tax	33,519
Total receivables	824,428
Prepaid expenses	135,629
Cash restricted for health benefit payments	228,611
Capital Assets	8,955,761
Amount to be provided for the retirement of general long-term debt	1,829,763
Total assets and other debits	$ 27,360,521
Accounts payable and accrued expenses	$ 2,048,735
Incurred but not received claims	2,184,000
Compensated absences payable	1,186,629
Notes payable	643,134
Liabilities payable from restricted assets	228,611
Total Liabilities	6,291,109
Investment in fixed assets	8,955,761
Fund balances:	
Reserved	5,197,526
Unreserved	
Designated for subsequent year's expenditures	1,212,309
Undesignated	5,703,815
Total fund equity	21,069,411
Total liabilities and fund equity	$ 27,360,521

Attachment X – Financial Reporting Requirements
Piedmont Behavioral Healthcare
SAMPLE

#4 & 5: Claims Processing Report

	Dates of Service			
	July	August	September	Total
Total Number of Claims Received	16,800	15,200	13,564	45,564
Clean Claims				
Number Received	13,085	12,000	11,200	36,285
Total Amount Paid	3,325,000	3,260,000	2,890,000	9,475,000
Current Pended Claims				
Number Received	935	900	500	2,335
Total Amount	101,000	89,000	78,000	268,000
Approved But Unpaid Claims				
Number Received	125	200	75	400
Total Amount	65,000	75,000	45,000	185,000
Denied Claims due to ineligible service or client				
Number Received	1,655	1,400	1,200	4,255
Total Amount Billed	28,000	21,000	17,000	66,000
Denied Claims not due to ineligible service or client				
Number Received	1,000	700	589	2,289
Total Amount Billed	22,000	18,000	12,000	52,000
Total - Should equal total number of received claims listed above	16,800	15,200	13,564	45,564
Unpaid clean claims past prompt pay requirements				
Number Received	0	0	0	0
Total Amount Outstanding	0	0	0	0
Total Amount of Interest Paid or Due	0	0	0	0

Month Paid							
July	450,000						
August	1,750,000	425,000					
September	825,000	1,800,000	455,000				
October	300,000	780,000	1,805,000	445,000			
November	110,000	305,000	805,000	1,801,000	435,000		
December	63,000	150,000	295,000	825,000	1,760,000	440,000	
January	2,000	88,500	155,000	300,000	750,000	1,795,000	425,000
February		1,300	60,000	160,000	275,000	805,000	1,805,000
March			24,600	60,000	165,000	325,000	800,000
Additional Payments	-	200	400	-	-	-	-

Dates of Service	July	August	September	October	November	December	January
Total Paid for Month	3,500,000	3,550,000	3,600,000	3,591,000	3,385,000	3,365,000	3,030,000
Estimated Total Claims Expense	3,500,000	3,550,000	3,600,000	3,650,000	3,450,000	3,565,000	3,500,000
Estimated IBNR **	-	-	-	(59,000)	(65,000)	(200,000)	(470,000)
Percent of Estimated Total Claim Expense Paid	100.00%	100.00%	100.00%	98.38%	98.12%	94.39%	86.57%

**Estimated IBNR is the Total Paid for Month less the Estimated Total Claims Expense

Attachment X – Financial Reporting Requirements

#1: SAMPLE ENROLLMENT REPORT:

Piedmont Behavioral Healthcare

	October Eligibles	October Clients Receiving Services	October Retro-Activity	November Eligibles	November Clients Receiving Services	November Retro-Activity	December Eligibles	December Clients Receiving Services	December Retro-Activity	Total Eligibles for Quarter	Total Clients Receiving Services for Quarter
TANF	20,000	14,840	81	20,000	14,700	61	20,000	14,333	46	60,000	43,873
Foster Care	30,000	14,840	81	30,000	14,700	61	30,000	14,333	46	90,000	43,873
Aged	15,000	9,000	81	15,000	10,000	61	15,000	11,000	46	45,000	30,000
Blind/Disabled < 21	10,000	9,000	81	10,000	8,500	61	10,000	8,300	46	30,000	25,800
Blind/Disabled > 21	5,000	4,000	81	5,000	3,000	61	5,000	3,500	46	15,000	10,500
CAP - MR/DD	20,000	14,840	81	20,000	14,700	61	20,000	14,333	46	60,000	43,873
Grand Total	100,000	66,520	567	100,000	65,600	427	100,000	65,799	322	300,000	197,919

Attachment 6-A SAMPLE REPORT

Piedmont Behavioral Healthcare

Analysis of Revenues and Expenses

1st Quarter 2005-2006 (July - September 2005)

	Medicaid B Wavier Capitation	Medicaid Fee For Service	Medicaid C Wavier Capitation	Medicaid Cap Supplies Fee For Service	State and Federal	Other	County	Total
REVENUE:								
SERVICE REVENUE	20,359,623.00	60,000.00	6,322,215.00	150,000.00	8,244,625.00	136,968.00	662,981.00	35,936,412.00
ADMIN REVENUE	1,934,164.19	5,700.00	600,610.43	-	783,239.38	-	-	3,323,713.99
TOTAL REVENUE	22,293,787.19	65,700.00	6,922,825.43	150,000.00	9,027,864.38	136,968.00	662,981.00	39,260,125.99
Risk Reserve Funds	407,192.46	N/A	126,444.30	N/A	N/A	N/A	N/A	533,636.76
SERVICE EXPENDITURES:								
Inpatient	1,500,000.00				500,000.00			2,000,000.00
Outpatient	2,750,000.00				1,750,000.00			4,500,000.00
Residential	5,000,000.00				5,000,000.00			10,000,000.00
ICF/MR	8,450,000.00				2,450,000.00			10,900,000.00
CAP	4,500,000.00	55,000.00	6,500,000.00					11,055,000.00
CAP Supplies				150,000.00				150,000.00
Community Service	200,000.00	5,000.00			4,555,000.00			4,760,000.00

TOTAL SERVICE EXPENDITURES:	22,400,000.00	60,000.00	6,500,000.00	150,000.00	14,255,000.00	-	-	43,365,000.00
% of Total Expenditures	0.52	0.00	0.15	0.00	0.33	-	-	1.00
ADMIN EXP-Distributed on % of Total Expenditures	796,513.32	2,133.52	231,131.10	5,333.79	506,888.27	-	-	1,542,000.00
Total Expenditures (Service & Adm)	23,196,513.32	62,133.52	6,731,131.10	155,333.79	14,761,888.27	-	-	44,907,000.00
PROFIT(LOSS) SERVICE FUNDS	(2,040,377.00)	-	(177,785.00)	-	(6,010,375.00)	136,968.00	662,981.00	(7,428,588.00)
PROFIT(LOSS) ADMINISTRATIVE FUNDS	1,137,650.87	3,566.48	369,479.33	(5,333.79)	276,351.10	-	-	1,781,713.99
PROFIT(LOSS)	(902,726.13)	3,566.48	191,694.33	(5,333.79)	(5,734,023.90)	136,968.00	662,981.00	(5,646,874.02)
RISK RESERVE BALANCE (not considered in P&L)	407,192.46	N/A	126,444.30	N/A	N/A	N/A	N/A	533,636.76

Appendix XVI - Penalties

ATTACHMENT Y

PENALTIES

Any instance of contract non-compliance described below except early termination will first result in implementation of a Corrective Action Plan. If this does not resolve the problem, the penalties described below may be initiated by DMA. The Corrective Action Plan must be submitted within 30 days of the date requested by DMA. The Corrective Action Plan will be subject to the approval of the DMA Director or his designee. Once the plan is approved, the LME has 60 days to implement the plan. The DMA Director or his designee will determine whether, once implemented, the plan is resolving the problem. Failure to resolve the problem may result in the penalties below:

Compliance Issue	Resolution/Penalty
Non-compliance with Federal, and State laws; placing health and safety of recipients in jeopardy and not acting to solve the problem; providing fraudulent information to recipients; offering or providing gratuities to public officials creating a conflict of interest as described in Part II, Section 1.0, Conflict of Interest; State and Federal Medicaid funds no longer available to provide payment.	Immediate termination
Claims are not paid by Piedmont to providers in a timely manner as specified in the contract. The LME shall follow North Carolina Prompt Pay Requirements as follows: within eighteen (18) calendar days after the LME receives an invoice/claim from a provider, the LME shall either (a) approve payment of the invoice/claim, (b) deny payment of the invoice/claim, or (c) determine that additional information is required for making an approval or denial. If payment is approved, the claim shall be paid within 30 calendar days after it is approved.	IF the LME fails to pay providers within these parameters, the LME shall pay to the providers interest in the amount of 8% of the amount owed in excess of the Prompt Pay Requirements.
Early contract termination by the LME.	The LME shall provide DMA with a plan to effectively transition consumers to Medicaid fee-for-service as specified in Part II 12.4. DMA may require the LME to pay the non-federal share of transitions (cost of EIS and MMIS and recipient notification)
Failure to submit encounter data, enrollment reconciliation reports or financial reports	Financial penalties may be imposed by reducing the monthly premium payment(s) by up to 5% of the subsequent month(s) capitation payment, pending receipt and acceptance of the respective report or data by DMA. One hundred percent (100%) of the LME's monthly capitation payment due shall be subject to financial penalties. (refundable upon receipt).
Failure to provide Medically Necessary services; inappropriate charges to Enrollees; Physician Incentive Plan non-compliance; falsifying information to Enrollees, DMA or THE DEPARTMENT; discrimination due to health status/service needs of Enrollees.	Financial penalties may be imposed by reducing the monthly premium payment(s) by up to 5% of the subsequent month(s) capitation payment, pending receipt and acceptance of the respective report or data by DMA. One hundred percent (100%) of the LME's monthly capitation payment due shall be subject to financial penalties.

Attachment Z

Medical Care Decisions
And Advance Directives
WHAT YOU SHOULD KNOW

What are My Rights?

Who decides about my medical care or treatment?

If you are 18 or older and have the capacity to make and communicate health care decisions, you have the right to make decisions about your medical/mental health treatment. You should talk to your doctor or other health care provider about any treatment or procedure so that you understand what will be done and why. You have the right to say yes or no to treatments recommended by your doctor or mental health provider. If you want to control decisions about your health/mental health care even if you become unable to make or to express them yourself, you will need an "advance directive."

What is an "advance directive"?

An advance directive is a set of directions you give about the health/mental health care you want if you ever lose the ability to make decisions for yourself. North Carolina has three ways for you to make a formal advance directive. One way is called a "living will"; another is called a "health care power of attorney"; and another is called an "advance instruction for mental health treatment."

Do I have to have an advance directive and what happens if I don't?

Making a living will, a health care power of attorney or an advance instruction for mental health treatment is your choice. If you become unable to make your own decisions; and you have no living will, advance instruction for mental health treatment, or a person named to make medical/mental health decisions for you ("health care agent"), your doctor or health/mental health care provider will consult with someone close to you about your care.

Doctor and each health care agent you named of the change. You can cancel your advance instruction for mental health treatment while you are able to make and make known your decisions, by telling your doctor or other provider that you want to cancel it.

Whom should I talk to about an advance directive?

You should talk to those closest to you about an advance directive and
your feelings about the health care you would like to receive. Your doctor or health care provider can answer medical questions. A lawyer can answer questions about the law. Some people also discuss the decision with clergy or other trusted advisors.

Where should I keep my advance directive?

Keep a copy in a safe place where your family members can get it. Give copies to your family, your doctor or other health/mental health care provider, your health care agent, and any close friends who might be asked about your care should you become unable to make decisions.

What if I have an advance directive from another state?

An advance directive from another state may not meet all of North Carolina's rules. To be sure about this, you may want to make an advance directive in North Carolina too. Or you could have your lawyer review the advance directive from the other state.

Where can I get more information?

Your health care provider can tell you how to get more information about advance directives by contacting:

Living Will

What is a living will?

In North Carolina, a living will is a document that tells others that you want to die a natural death if you are terminally and incurably sick or in a persistent vegetative state from which you will not recover. In a living will, you can direct your doctor not to use heroic treatments that would delay your dying, for example by using a breathing machine ("respirator" or "ventilator"), or to stop such treatments if they have been started. You can also direct your doctor not to begin or to stop giving you food and water through a tube ("artificial nutrition or hydration").

Health Care Power of Attorney

What is a health care power of attorney?

In North Carolina, you can name a person to make medical/mental health care decisions for you if you later become unable to decide yourself. This person is called your "health care agent." In the legal document you name who you want your agent to be. You can say what medical treatments/mental health treatments you would want and what you would not want. Your health care agent then knows what choices you would make.

How should I choose a health care agent?

You should choose an adult you trust and discuss your wishes with the person before you put them in writing.

Advance Instruction for Mental Health Treatment

What is an advance instruction for mental health treatment?

In North Carolina, an advance instruction for mental health treatment is a legal document that tells doctors and health care providers what mental health treatments you would want and what treatments you would not want, if you later become unable to decide yourself. The designation of a person to make your mental health care decisions, should you be unable to make them yourself, must be established as part of a valid Health Care Power of Attorney.

This document was developed by the North Carolina Division of Medical Assistance in cooperation with the Department of Human Resources Advisory Panel on Advance Directives 1991. Revised 1999.

Other Questions

How do I make an advance directive?

You must follow several rules when you make a formal living will, health care power of attorney or an advance instruction for mental health treatment. These rules are to protect you and ensure that your wishes are clear to the doctor or other provider who may be asked to carry them out. A living will, a health care power of attorney and an advance instruction for mental health treatment must be written and signed by you while you are still able to understand your condition and treatment choices and to make those choices known. Two qualified people must witness all three types of advance directives. The living will and the health care power of attorney also must be notarized.

Are there forms I can use to make an advance directive?

Yes. There is a living will form, a health care power of attorney form and an advance instruction for mental health treatment form that you can use. These forms meet all of the rules for a formal advance directive. Using the special form is the best way to make sure that your wishes are carried out.

When does an advance directive go into effect?

A living will goes into effect when you are going to die soon and cannot be cured, or when you are in a persistent vegetative state. The powers granted by your health care power of attorney go into effect when your doctor states in writing that you are not able to make or to make known your health care choices. When you make a health care power of attorney, you can name the doctor or mental health provider you would want to make this decision. An advance instruction for mental health treatment goes into effect when it is given to your doctor or mental health provider. The doctor will follow the instructions you have put in the document, except in certain situations, after the doctor determines that you are not able to make and to make known your choices about mental health treatment. After a doctor determines this, your Health Care Power of Attorney may make treatment decisions for you.

What happens if I change my mind?

You can cancel your living will anytime by informing your doctor that you want to cancel it and destroying all the copies of it. You can change your health care power of attorney while you are able to make and make known your decisions, by signing another one and telling your doctor or other provider that you want to cancel it.

Stakeholders Global CQI Committee Meeting

October 13, 2006

Don Bovender - Provider Chair

Jill Queen - PBH Co-Chair

Agenda

Review/Approval of Minutes

New Business: NC Quality Strategy presented by Deborah Bowen

New Business: 1- Provider Performance Profile presented by QM
2- Mystery Shopper Program presented by QM
3-2006-2007 Meeting Schedule

Review reports on CQI activities:
1-Complaint/Grievance Data Report
2-Consumer Satisfaction & Outcome Data Report
3-Access Data Report
4-Incident Report Data
5-Restrictive Intervention Data
6-Billing Audit Data
7-Provider Monitoring Review Data
8-System Quality Performance Data Report
9-Performance Indicators& Performance Improvement Projects

Old Business: 1-GCQI Policy/Procedure
2-Quality Improvement Projects for the Network
3-Discussion of Sub-Committee membership, meeting schedule and activities
4-Recruitment of new members

Standing Agenda Items: 1-Discussion of Sub-Committee Activities
2-Discussion of Barriers to Services
3-Discussion of Updates
4-Discussion of Accomplishments/Successes

Next Meeting Date:

HMO Managed Care/ DMA
QM Meeting – 1st Quarter

Wednesday, March 8, 2006
1:00 PM – 2:00 PM (Eastern Time)

Tele-Conference Call-in Phone Number: (919) 733-2438

AGENDA

1. Welcome

2. Approval of Minutes from last meeting (11/30/05)

3. Mecklenburg County – Program Ops Update LaRhonda Cain

4. HMO Contract Update Deborah Bowen

5. MPRO/EQR Activities for 2006: Angie Beattie/ Cathy Hefner

   Validation Performance Improvement Project's – due DMA 6/30/06

   Validation Performance Measures – due DMA 6/30/06

   Regulatory Contract Compliance Review

   HMO Financial Analysis

6. Performance Improvement Project (PIP's) Update WellPath

7. Other Issues/ Discussion

8. Next Meeting Date: June 14, 2006 @ 1:00- 2:00PM

HMO/DMA Quarterly QM Meeting

March 8, 2006 (for 1st Quarter)
1:00pm – 2:00pm Tele-Conference

Attendees: WellPath - Esther Watson, Cheryl Harris, Gail Doria; IPA EHS - Marilyn Diaz, Mary Miller, Roxanne Hyde, Kavita Ratan
DMA - Anne Rogers, Susan Bostrom, Deborah Bowen, and Darryl Frazier
MPRO – Angie Beattie and Cathy Hefner

Agenda Item	Discussion	Action Items
Welcome Approval of Minutes	• Minutes from the previous QM meeting held 11/30/05 were reviewed. Noted that one attendee's name had been omitted.	Minutes were approved as written. Correction made to attendees.
Old Business Items	• All follow-up items from the previous meeting on 11/30/05 had been addressed and resolutions documented in the minutes of this meeting.	None
Mecklenburg Update	• Darryl Frazier reported that the SouthCare member enrollment for the month of March 2006 is 8,586 (reflects an increase of 106 from February). • The next Plan Mobilization Meeting (PMM) scheduled to be held in March at Mecklenburg County DSS has been cancelled due to no issues. • Four new Health Check Coordinator positions have been approved for Mecklenburg County.	Informational
HMO Contract Update	• Deborah Bowen informed the committee that at this time there was nothing new to report from contracting.	Informational
MPRO/ EQR 2006 Activities Update	• Cathy Hefner presented the following 2006 EQR Activities schedule: • **Validation of Performance Improvement Projects (PIP's):** Well Path's PIP's are due to be submitted to DMA by 6/30/06. MPRO begins desk review upon receipt from DMA. On-site TBD, probably late August. • **Validation of Performance Measures:** Well Path's Performance Measures are due to be submitted to DMA by 6/30/06. MPRO begins desk review upon receipt from DMA. On site TBD, probably late August.	Refer to document with 2006 EQR Activities for WellPath.

	• **Contract Compliance:** Cathy explained that this is a review of the contract requirements between DMA and Well Path to determine if activities are met. MPRO will be requesting documentation from WellPath to begin the desk review process. On-site TBD. • **HMO Financial Analysis:** MPRO has received WellPath's 4th quarter financial reports and has forwarded them to HMA for analysis. On-site TBD and will take place at the Raleigh location. • **Focused Care Studies:** DMA will need to meet with Well Path to discuss study topics. Anne Rogers informed the committee that a draft listing of 2006 Focused Study Topics for Consideration will be presented at the next Clinical Director's meeting in March. This document will be sent to Well Path for their information.	
WellPath PIP's Update	• Marilyn presented the following PIP updates: • Adolescent Immunizations – Continue to see improvement in the rates. Combo-1 at 31% and Combo-2 at 14% secondary to their outreach. • Health Check Screening – 2004 result was 69.03% and preliminary 2005 result at 61.14%. • Lead Screening – 2004 result was 23% and preliminary 2005 result 30.83%. • Initial Health Assessment – 2004 result was 24.12% and the preliminary 2005 result at 26.11% (based off notification date).	Informational
Other Issues/ Discussion	• Esther Watson had a question regarding the topics for Focused Care Studies. Most of the study population is in Community Care of NC and the Clinical Directors of Community Care will be reviewing the draft of Topics for Consideration for the 2006 Focused Studies at their March meeting.	Informational
Next QM Meeting	• **Next meeting is scheduled for Wednesday, June 14, 2006 at 1:00pm**	

REMINDER: Final HMO/DMA Quarterly QM Meeting date is June 14, 2006 from 1:00-2:00pm ET
Teleconference call-in number is: (919) 733-2441

Recorded by: Susan Bostrom, RN

HMO Managed Care/ DMA
QM Meeting – 2nd Quarter

Wednesday, June 14, 2006
1:00 PM – 2:00 PM (Eastern Time)

Tele-Conference Call-in Phone Number: (919) 733-2441

AGENDA

1. Welcome
2. Approval of Minutes from last meeting (3/08/06)
3. SouthCare Transition Update — Terri Paynter
4. EQR/ MPRO Activities Update — Angie Beattie/ Cathy Hefner
   - MPRO Site Visit 7/20/06
   - Validation of PIP's
   - Validation of Performance Measures
   - ISCA Assessment
   - Quarterly Financial Analysis
5. Other Issues/ Discussion
6. Closing Comments

HMO/DMA Quarterly QM Meeting

June 14, 2006 (for 2nd Quarter)
1:00pm – 2:00pm Tele-Conference

Attendees: WellPath - Esther Watson, Cheryl Harris, Gail Doria; IPA EHS - Marilyn Diaz, Mary Miller, Roxanne Hyde, Kavita Ratan
DMA - Susan Bostrom, Deborah Bowen, and Terri Paynter
MPRO - Cathy Hefner

Agenda Item	Discussion	Action Items
Welcome Approval of Minutes	• Minutes from the previous QM meeting held 3/08/06 were reviewed.	Minutes were approved as written.
Old Business Items	• No follow-up items identified.	None
SouthCare Transition Update	In LaRhonda Cain's absence, Terri Paynter reported to the committee that the transition process is going smoothly. DMA has been having weekly internal meetings to coordinate this process with WellPath and PCG. • Recipient letters were sent starting yesterday, 6/13. • Provider recruitment is going well. • Recent e-mail sent to WellPath with clarification on newborns born after 6/28 and regarding kick payments. • Managed Care will check on the next transition of care list.	Informational
HMO Contract Update	• Deborah Bowen contacted John Evers in the Contracts office, and an executed copy of the Amendment to the WellPath contract which moved the termination date to 7/31/06 was sent to Peter Chauncey via FedEx on 6/13.	Informational
MPRO/ EQR 2006 Activities Update	• Cathy Hefner presented the following 2006 EQR Activities update: • **Validation of Performance Improvement Projects (PIP's):** WellPath's PIP's (same 4 as last years) are due to be submitted to DMA by 6/30/06. • **Validation of Performance Measures:** WellPath's Performance Measures (non-HEDIS measures) are due to be submitted to DMA by 6/30/06. MPRO has received the favorable NCQA-certified HEDIS audit report.	MPRO reminded Well Path to review any recommendations from last year's Validation site visit, and to make sure the information is available for this year's review.

	• **ISCA Assessment:** MPRO only needs any new updates since last year's ISCA evaluation. • **Site Visit for Validation:** MPRO will conduct a site visit to WellPath on July 20, 2006 for Validation of the PIP's, Performance Measures, and ISCA. • **Contract Compliance:** Cathy explained that due to the HMO contract termination, this activity would not be conducted. • **HMO Financial Analysis:** On 4/20/06 MPRO and HMA conducted the on-site visit to Well Path for the Financial Analysis with favorable findings and the final report has been distributed.	MPRO reminded WellPath that it is still necessary for them to submit a Q2 06 Financial report, and also for July. HMA will review these.
Other Issues/ Discussion	• DMA thanked everyone for their hard work, cooperation, and input.	None
Next QM Meeting	• This is the final Quarterly QM meeting due to the HMO contract termination which is effective 7/31/06.	

Recorded by: Susan Bostrom, RN

Piedmont / DMA Quarterly QM Meeting
February 21, 2006 (for 1st Quarter)
Teleconference from 10:00- 11:00 am

Attendees: PBH - Darlene Steel, Bill Rankin, Colleen Konicky, Sue Marchetti, David Jones, Sneha Desai
MPRO - Cathy Hefner
DMA - Susan Bostrom, Marilyn Southard, Carolyn Wiser; DMH – Shealy Thompson

Agenda Item	Discussion	Action Items
Welcome Approval of Minutes	• Minutes from the previous QM Meeting held 10/18/05 were reviewed.	Minutes were approved as written.
EQR/ MPRO Activities	Cathy Hefner presented the following EQR activities timelines for 2006: • **Validation of Performance Improvement Projects (PIP's):** Piedmont's PIP's are due to be submitted to DMA by 7/31/06. MPRO begins desk review upon receipt from DMA. On-site TBD, probably late August. Discussion about baseline data to correlate with start-up date 4/01/05. • **Validation of Performance Measures:** Piedmont's Performance Measures are due to be submitted to DMA by 6/30/06. MPRO begins desk review upon receipt from DMA. On-site TBD, probably late August. • **PBH Encounter Data Validation:** Since PBH is not yet submitting encounter data, because of DMA system changes, MPRO will only evaluate PBH's IS system capabilities. MPRO is currently reviewing the 2005 Mercer Readiness Review report and will be requesting additional information from PBH.	Refer to MPRO 2006 EQR Activities schedule for Piedmont Behavioral Health.
DMA Behavioral Health Update	• Marilyn Southard informed the committee that she is currently working on the '05 audits for Innovations. Carolyn Wiser from DMA BH introduced herself and she is replacing Marie Britt who resigned.	Informational
Piedmont Program Updates	• **PBH Consumer/Parent/Guardian/Family Member Survey:** Since the ECHO survey was no longer required by NCQA, PBH has developed a Consumer Satisfaction Survey tool. Darlene Steel, Director of Quality, presented the survey tool which has been revised taking into consideration MPRO's feedback. The results of the first year survey will be the initial benchmark.	DMA and DMH reviewed the revised PBH Consumer Satisfaction Survey, and had no further suggestions. The Consumer Survey tool is approved for use.

	• **Annual PBH Provider Satisfaction Survey:** Sue Marchetti, Director of Provider Services, presented the PBH Provider Satisfaction Survey which has been revised taking into consideration MPRO's feedback. The finalized tool will be implemented 3/01 and the survey results should be back by June. • There was discussion of using a 4-point scale, instead of a 5-point scale, for scoring of these surveys. PBH will keep the current 5-point scoring scale. • **PBH's Performance Improvement Projects for 2006:** The committee reviewed the list of topics for PBH's Performance Improvement Projects for 2006, which Darlene previously submitted. This list is "more aggressive" then the DMA contract requirements because PBH is also preparing for NCQA accreditation. • PBH is transitioning to a new benefit package and cannot keep internal Case Management.	DMA and DMH reviewed the revised PBH Provider Satisfaction Survey and had no further suggestions. The Provider Survey tool is approved for use.
Review of PBH Performance Indicators	• DMA and DMH recently reviewed the PBH Performance Indicator list and this listing has been consolidated and abbreviated. It needs to be emphasized that if an indicator on the revised list is now "deleted", the contract requirement itself is not being deleted, but is just limiting what needs to be reported to DMA, DMA BH, and DMH. Also DMH will be internally calculating certain indicators (and sharing the data with DMA) to evaluate PBH's performance.	A teleconference meeting is scheduled for March 6th at 2PM to present this revised indicator list to PBH for their questions and comments. This listing will then be presented at the PBH Intra-Departmental meeting on 5/11/06.
Other Issues	• The committee had no other issues for discussion.	None
Next QM Meeting	• **Next meeting is scheduled for Tuesday, May 16, 2006 at 10:00 AM**	

<u>Next PBH/ DMA Quarterly QM Meeting is scheduled for: Tuesday, May 16, 2006 from 10:00 – 11:00 AM</u>
Teleconference call-in number is: (919) 733-2416

Piedmont Behavioral Healthcare/ DMA
QM Meeting - 2nd Quarter

Tuesday, May 16, 2006
10:00AM – 11:00AM

Tele-Conference Call-in Number: (919) 733- 2416

AGENDA

1. Welcome

2. Approval of Minutes from last Meeting (2/21/06)

3. EQR/ MPRO 2006 Activities Update — Angie Beattie/ Cathy Hefner

4. DMA Behavioral Health Program Update — Carolyn Wiser/Marilyn Southard

5. Piedmont Program Update — Darlene Steel

   - Status Consumer Survey

   -Quarterly Reports (Q1 06) - trends?

6. Other Issues/ Discussion

7. Next Meeting Date: August 15, 2006 @ 10:00-11:00AM

Piedmont / DMA Quarterly QM Meeting
May 16, 2006 (for 2nd Quarter)
Teleconference from 10:00- 11:00 am

Attendees: PBH - Darlene Steel, Colleen Konicky, Sneha Desai, and David Jones
DMA - Susan Bostrom and Marilyn Southard
MPRO - Angie Beattie and Cathy Hefner

Agenda Item	Discussion	Action Items
Welcome Approval of Minutes	• Minutes from the previous QM Meeting held 2/21/06 were reviewed.	Minutes were approved as written.
EQR/ MPRO Activities	Cathy Hefner presented the following update for 2006 EQR activities: • **Validation of Performance Improvement Projects (PIP's):** Piedmont's PIP's are due to be submitted to DMA by 7/31/06. MPRO begins desk review upon receipt from DMA. • **Validation of Performance Measures:** Piedmont's Performance Measures are due to be submitted to DMA by 6/30/06. MPRO begins desk review upon receipt from DMA. • **PBH Encounter Data Validation:** MPRO will be evaluating Piedmont's IS system capabilities since PBH is not yet submitting encounter data. MPRO is currently reviewing the 2005 Mercer Readiness Review report and will also review the Mercer findings from the DMA/DMH on-site review which was held on 4/12-13.	Informational
DMA Behavioral Health Update	• Marilyn Southard informed the committee that she is currently participating in hearings, including some future PBH hearings. Carolyn Wiser is on vacation.	Informational
Piedmont Program Updates	• **PBH Consumer/Parent/Guardian/Family Member Survey:** PBH is in the process of administering the Consumer Survey and the final survey results should be available by mid-June. No barriers have been encountered. The results of the first year survey will be the initial benchmark. • **Annual PBH Provider Satisfaction Survey:** the PBH Provider Satisfaction Survey is also currently being administered and the final survey results should also be available in June.	PBH Consumer Satisfaction Survey is currently being administered. PBH Provider Satisfaction Survey is currently being administered.

	• The DMA/DMH on-site operational review was conducted by Mercer on April 12-13, and one identified opportunity for improvement is the need for enhanced IS system support of the UM and Access departments. • Mercer also identified the need to strengthen the internal QI process. • PBH is in the process of applying for mental health trust fund monies for a proposal to fill in the gaps in the transitional housing program for adults. • PBH continues to address the new benefit package changes. • It is difficult to look at trends until final changes are made in the data reporting formats.	QM is meeting with UM to review and develop strategies to improve their internal QI process.
Revised PBH Performance Indicators	• The revised, consolidated PBH Performance Indicator listing was presented at the PBH Intra-Departmental Monitoring Team meeting on 5/11/06. The revised listing is (3) pages with 35 indicators.	None
Other Issues	• The committee had no other issues for discussion.	None
Next QM Meeting	• **Next meeting is scheduled for Tuesday, August 15, 2006 at 10:00 AM**	

Next PBH/ DMA Quarterly QM Meeting is scheduled for: Tuesday, August 15, 2006 from 10:00 – 11:00 AM
Teleconference call-in number is: (919) 733-